			1 - State Of Maryland / L State Registrar	Certificate of			giene Reg. No.2 () () ]	25001
Ī	Physici		1. Decedent's Name (First, Middle, Last) Thomas E. Hohmann			2. Date of De Month July 2	ath 29 2007 <sup>Year</sup>	3. Time of Death 17:48 <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Univ. of Maryland Medical Ctr		r Location of Death	J 41 1	4c. County of Dea	uth
90	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt		If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da June 25	y, Year) C	thplace (State or Foreign ountry) Virginia
	Maryland f show ied at	tor	10a. State 10b. County 10c. City, Town Maryland Montgomery Rockvi.					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 3a or 28a st be notif	al Directo	10e. Street and Number 216 Monroe Street	10f. Zip Code 20852			10g. Citizen of What C	•
900	d within 72 hours after death with the Maryland glene. rr than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Mamed 3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1951-53	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No		cify Yes or No Rican, etc.)	14. Race - Am Black, Whi	te, etc.
Maryland 21215-0036		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Attorney	oation during most of workin d)	g	16b. Kind of Business U.S. Gover	_
land 2	be file ntai Hy id othe event,	To Be Co	17. Father's Name (First, Middle, Last) William Edward Hohmann	recorney	18. Mother's Name Margaret		Maiden Surname)	
	is 1 and 2 should of Health and Men item 27 is marke other traumatic.		Martha R. Mindte / Sister 720	. Mailing Address (Street  O Smallwood	Road, Roc			
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important; If item 27 is marke any injury or other traumatic once.		4 □ Donation 5 □ Other (Specify) Gate of	Disposition (Name of ry, crematory or other place Heaven Cemeter	y Aug. 7,			ing, Maryland
Bal	permii Depar Impor any ir		21. Signature of Funeral Service Licensee M00896	300 W. Mont	tgomery Av	e., Ro		20850-2805
) =	Physician /Medical		23a. Part1. Enter th diseas), or complications that caused the death. Do not shock, or hear trailed List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sepsis					Approximate Interval Between Onset and Death 21 days
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or as a consequence of Chronic Pancro  Due to (or a		ith pseud	docyst	S	1 month
68760,	rificate be executed ig physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen	of):				
.O. Box	death cei e attendir d for use	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		23d. Date of de Month	l Blivery Day Year
Q.	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in Acute renal failure, coronary	the underlying cause given artery discourse given are given artery discourse given are given artery discourse given are given arterial given are	ven in Part I. 1 Sease		obacco use contribute Yes 2 □ No 3 □ F	to the cause of death?  Probably 4 Unknown
or Vital Records,	The larate has	Completed	Anemia			24a. Was autor perfo		utopsy findings available completion of cause of s
or Vita	Physician: Th r this certificate ral director, pag	To Be		Introduction of the state of th	4 Li Nursing Hon	(Check only one 5 ☐ Resi	one) dence 6 □Other (Sp	ecify)
Division	or Attending ter death. Irector: Afte I by the fune	Certification:		njury Wor M 1□	Yes 2□No		how injury occurred  Street and Number or F wn, State)	Rural Route Number,
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the tind/or investigation, in my	me, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
		Σ	29b. Signature and title of certifier  Sund Laish MD	13194			Aug 2, 20	19 19 ay, Year)
	621		30. Name and address of person who employed cause of death them 230) of Dr. Zan Zaidi 227 Person San Zaidi 230 C		re, Md 2	1201		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 6 2007 32. Reistrar's Signature	freele				

DHMH 17 Rev 1/2001

1 - For Every State Registrar Certificate of Death Reg. No.	the second secon
1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Decedent's Name (First, Middle, Last)  2. Date of Death Month Decedent's Name (First, Middle, Last)  2. Date of Death Month Decedent's Name (First, Middle, Last)	
Medical CARTER OSBURN HOFFRAX, SR. Ragues S	02 2007   11:30a <sup>™</sup> c. County of Death
Examiner 4a. Facility Name (If not institution, give street and number)	BALTIMORE
GREATER BALTIMORE PEDICAL CENTER 16 Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth	Birthplace (State or Foreign
Funeral Director  5. Social Security Number 219–22–9837  Usual Residence of Decedent  7. Age (In yrs. last birthday) 8. Sept. 3, 192	
100 City Town or Location	10d. Inside City Limits 1 □ Yes ※XXNo
MD Baltimore Lutherville  10e. Street and Number  10g. C	itizen of What Country?
106. Street and Number 106. Street and Number 21093	USA
615 Brightwood Club Drive 21093  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerfo Rican, etc.)	14. Race - American Indian,
1 Never Married 2 Married 1 M Yes 2 No	Black, White, etc.  Specify: white
Section of the state of the sta	Kind of Business/Industry
15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  16b. (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maide	restments
N 9 5 2 2 1 3 18. Mother's Name (First, Middle, Maide	en Surname)
Johns Janney Hoffman Margaret O	
Johns Janney Hoffman  Margaret O  17. Father's Name (First, Middle, Last)  Johns Janney Hoffman  Margaret O  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City  Mrs. Ann Hoffman — wife 615 Brightwood Club Drive, Luther  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c.	
→ ≥ v = v = \ Mrs. Ann Hoffman - wife 615 Brightwood Club Drive, Luther	ville, MD 21093  Location - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	_
1   Burial   2   Cremation   3   Removal from State   4   Donation   5   Other (Specify)   Greenmount   Crematory   8/4/07   Bal   22. Name and Address of Facility   21. Signature of Funeral Service Licensee   Mitchell-Wiedefeld   Funeral Ho	timore, MD
20a. Method of Disposition (Name of cemetery, crematory or other place)  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Mitchell-Wiedefeld Funeral Ho 6500 York Road, Baltimore, MD	ome, Inc. 0 21212
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final	Onset and Death 4 days
/Medical disease or condition resulting in death)  Duc o (or as a consequence of):	N
Examiner Chronic obstructive Pulmonary	Discass 1 year
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
fi any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
al E)	
68760, illicate be ex ga physician as the burial edical E	
Use 2 Down in the past 12 months?  If FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ Down in the past 12 months?	23d. Date of delivery  Month Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Month Day Year
O e di proper de la company d	co use contribute to the cause of death?
ý s en	2 No 3 Probably 4 Unknown
Completed	24b. Were autopsy findings available prior to completion of cause of
autopsy performed 1□ Yes 2 M	death?
The second secon	
25. Was case referred to medical examiner?  1	e 6 □Other (Specify)
The state of Death Search of D	njury occurred
1 Matural 5 Pending (Montan, Day Year)  1 Matural 5 Pending (Montan, Day Year)  M 1 Yes 2 No	Land Number - Dural Payto Number
27. Manyler of Death   1   Natural   2   Accident   3   Suicide   4   Homicide	t and Number or Rural Route Number, tate)
The state of the cause of the c	e(s) and manner as stated.
29a. Certifier 19 Certifying Physician: To the best of my knowledge, death occurred at the line, date and place, and due to the case of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.  29b. Signature and title of certifier 29c. License number 29d.	
29b. Signature and title of certifier 29d.	Date signed (Month, Day, Year)
1 290. Signature and the offering.	
Liblian of m Conner D42129	9 - 0 /
29d. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William D. McConnell (30) N. Charles Begistrar  31. Date filed (Month, Day, Year)  32. Egistrar's Signature  AllG 0 6 2037	Hinere MD 212

			1 - For State Registrar		or ivial	,	ertificate o	f Death	,	Reg. No.		25000
	Physici		Decedent's Name (First, Midd  Boman  B.	le, Last)	Irani				2. Date of Dea Month Augus	Day	Year 2007	3. Time of Death  9:18 P N
	/Medic Examin		4a. Facility Name (If not institution Shady Grove Ac		imber) HUSP	ital	4b. City, Town	, or Location of Deat		4c. Cou	inty of Death	nery
-	Funeral Director		5. Social Security Number 216-94-8817	6. Sex 1 ☑ M 2 ☐ F		(In yrs. last birtho	(ay) If Under 1 Ye	ar If Under 24 Hrs		h y, Year)		place (State or Foreig
	yland how at		Usual Residence of Decedent  10a. State 10b. County	1		10c. City, Town o	r Location				1	0d. Inside City Limits
	ne Ma 18a-fs otified	Director	Maryland Montgo	mery		Gaithers				40- 011	-634510	1 ▼Yes 2 No
	with the or 2 the no		10e. Street and Number				10f. Zip Code				of What Cour	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11.41 Southern Night  11. Marital Status  1 Never Married 2 Mai  3 Widowed 4 Divorced	12. Was Der Armed F ried 1 Tyes	orces? 2 ☑ No ive		20879  13. Was Decedent of If Yes, specify C	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. F	States Race - Americ Black, White, ecify: As	an Indian,
mai yiaila E1E19 0000	thin 72 hou le. lan "natura Medical E	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed College	) (1-4or 5+)	) (%	fe. DO NOT use ret	ne during most of wo ired)	rking		of Business/In	
	led wi lygien her th t, the	Co	12	/ cot)		Data	Entry Clerk		me (First, Middle,		alth Car	`e
2	antal F ental F ed ot	Be	17. Father's Name ( <i>First, Middle</i> Behram Irani	, Last)					o B. Irani		name)	
,	2 should and Me Is mark aumatic	은	19a. Informant's Name/Relation	ship (Type. Print)		19b. N	lailing Address (Stre	et and Number or R			wn, State, Zip	Code)
	1 and 2 Health a tem 27 Is		Shernaz Irani / Wi	fe		1141	Southern	Night Lane	Gaithersbu	rg MD	20879	
	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	State	20b. Place of D cemetery,	isposition (Name of crematory or other p	olace)	Date	20c. Location	on - City or To	own, State
	permir. Pages Department of I Important; If Its any injury or o		4 Donation 5 ☐ Other (	Specify)		Parklawn		8/4/	2007	Rockvil	le, Mary	/land
3	permit. Departr Importa any inju		21. Signature Funeral Service	Licensee	1.1.1	/.	22. Name and Ad		04.6 1.6			-1 MD 20707
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the	he death. Do not		ral Home 76 dying, such as cardia			oad Laur	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition				ac dus	rhythn	110		11	Onset and Death mmechat
	/Medical Examiner		resulting in death)	Due to	(or as a		cardia	rhythm	rction			mmediai
50	rincate be executed g physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c. Cox	rond	consequence of) $\mathcal{Q}_{\mathcal{N}} / \mathcal{Q}_{\mathcal{Q}}$ cons. [uence of)	rtery ,	diseas-	2			years
	I to the Toppital of Attending Prysician: The law requires that the deam certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 nant at ti	f pregnancy □ □ Fetal death me of death	3 □Ectopic pregna 5 □ Other (specify)				Date of delive	ery Day Year
	s man ned by deta	y Ph	Part II. Other significant condit	ions contributing to	death but	not resulting in th	e underlying cause	given in Part I.	23e. Did to	obacco use c	contribute to t	he cause of death?
	equires an sign		Ļ						1 🗆 🗅	Yes 2 N	o 3 ☐ Prot	oably 4 □Unknow
	ysician: The law re is certificate has ber director, page 2 sho	Completed							24a. Was autor perfo 1□ Yes		4b. Were auto prior to co death? 1 ☐ Yes	psy findings availab mpletion of cause of 2 No
	siciar certifi rector	o Be	25. Was case referred to medici examiner?	Hospital:		0 0 EB/0		Other:	ath (Check only o			
	h. After this funeral di		1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient of Injury	28b. Tin	tient 3 DOA	4∐ Nursing l njury at Vork?	Home 5 ☐ Resident Properties 1			(y)
	ath. or; Aft he fun	atio	- Dittoldelle	igation	nth, Day	Year) Inju		☐Yes 2☐No				
	s after de al Directu ed in by t	Certification:	3 Suicide 6 Could 4 Homicide deteri	minod Zoe. Flat	e of injur ding, etc.	y - At home, farm (Specify)	, street, factory, office	ce	28f. Location (S City or Tox		umber or Rura	al Route Number,
	o the nospital of Atten within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certify (Check only one) 1 Certify 2 Medica	ng Physician: To the I Examiner: On the and ma	e best of basis of e nner state	examination and/	leath occurred at the or investigation, in n	e time, date and plac ny opinion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as s ice, and due t	stated. to the cause(s)
1	withi To th	M	29b. Signature and title of certification of the Cambridge of the Cambridg					5/79/			gned (Month,	Day, Year) 2007
Ė	t 1		30. Name and address of person Tamara L. Kil	who completed car	ise of dea	ath (Item 23a) (Ty Medic	pe, Print) al Cente	v Drive	Pockvi	11e,1	Mb	20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 6 2007

32. Registrar's Signature

			1 - For State Registrar	ate of Mar	yland / Depa <i>Ce</i> a	artmen <i>rtificat</i>			ind M		giene Reg. No.	201	250	01
	Dhyaisi		Decedent's Name (First, Middle, Last)	<del>".</del>						2. Date of De	ath	V	3. Time of D	Death
	Physici /Medi		Pollyann Louis	se Johns	son					Month August	Day 2	2007	1830	М
	Examir	ner	4a. Facility Name (If not institution, give stree Carroll Hospital (				Town, or	Location of ster		_	4c.	County of Dea	ath	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M		In yrs. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bird (Month, Da		C	rthplace (State or ountry)	Foreign
	D		Usual Residence of Decedent  10a. State 10b. County							April	2 19	45		
	Maryla f eho	ō	MD Carroll		Oc. City, Town or Lo Sykesvill								10d. Inside City	
	r 28a-	Irect	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of What C		π
	23a o	aD	7638 N. Schoolhouse	Road			2178	34			USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Zi is marked other then "natural; or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Exercities must be notified at once.	by Funeral Director	1 ☐ Never Married 21X Married 1	Vas Decedent Event Forces?  ☐ Yes 2☐ No Yes, Give X		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	jin? (Spec Puerto P	cify Yes or No Rican, etc.)		4. Race - Am Black, Whi	te, etc.	
Ş	hours fural',	d ba	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educatio	ear or Dates:			Λ						Lack	
215	hin 72 9n "na Medic	Completed	(Specify only highest grade cor	npleted) college (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	urina most :	of workin	g	16b. Kir	nd of Business	/Industry	
2	ygiene ygiene her the		12		inst	ructi						cation		
Baltimore, Maryland 21215-0036	d be fi	o Be	17. Father's Name (First, Middle, Last) William S. Hudson, S	r.						(First, Middle, ginia		,		
ary	shoul and Me s mark	ဥ	19a. Informant's Name/Relationship (Type, F		19b. Mailir	ng Address	(Street a			Route Numbe			Zip Code)	
Σ	and 2 eelth a m 27 i		Kenneth Johnson (spo		7638	N. So	choo!			., Syke				
Jore	ages 1 or of H or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	val from State	20b. Place of Dispo cemetery, cren	natory or ot	ther place	- 1		ate		cation - City or		
ij	nit. Prestment ortant		4 ☐ Donation <sup>A</sup> 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		All Count					/	-	sville,		
<u>~</u>	Dep Imp		Parge Harght Ster	bert	P	.O. B	ox 1	95 Sy	наід kesv	nt rund ille, l	eraı MD 23	ноте & 1784	Chapel	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused thuse on each line.	e death. Do not ente	er the mode	e of dying	, such as c	ardiac or	respiratory ar	rest,		Approximate Interval Betwee	
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	POXIC	- trepl	MO	2AH	my					Unset and De	atri
Н	Examiner		Convention for the first one fixture	Due to (or as a c	onsequence or);									
۳	De its	lue.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):									
p.	xecute and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):							_		
8760,	cate be executed physicien and the burial-transit	dlcalE	d											
	entifica ing ph e as th	Medi	IF FEMALE:									- 000		
Вох	death certific e attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	yes, outcome of p □Live birth 2 [ □Pregnant at tim	Fetal death 3	Ectopic pre					2	3d. Date of de. Month	livery Day Yea	ar
Р. О.	0 40 2	hysi		Unknown	le di dea(i) 5	Curer (spe	ciiy)							
Vital Records, F	requires that the de een signed by the a hould be detached t	Completed by P	Part II. Other significant conditions contribut  Coces hive Head	ing to death but n	ot resulting in the un	iderlying ca	iuse giver	n in Part I.		23e. Did to			the cause of dea	
000	law require as been sign 2 should b	plet	Cowning the	a Dis	Pa39				_	24a. Was a		24b. Were au	itopsy findings av	aılable
<u> </u>	: The lav cete has page 2:	Con								autops perfor 1 Yes	med? 2 No	death?	completion of cause 2□ No	se of
	sician: Th certificete irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospit	al:			Other			Check only or			11-11-1	
0		آن: 1	27. Manner of Death 28	a. Late of Injury	2 ER/Outpatient		Sc. Injury	4 🗀 Nurs		e 5 Resid			cify)	
SIO	ttending f death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ea <i>r)</i> Injury	М		es 2□No	0					
_	5 W 5 C	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	et, factory,	office		28	of Location (S City or Town	treet and n, State)	Number or Ru	ural Route Numbe	r,
		edical	29a. Certifier (Check only one)  Certifying Physicien (Check only one)	: To the best of m on the basis of exited and manner stated	amination and/or inv	occurred a estigation, i	t the time in my opii	, date and nion, death	place, an occurred	d due to the c l at the time, d	ause(s) a late and p	nd manner as place, and due	stated. to the cause(s)	
	To th within To th compl	₩ W	29b. Signature and title of certifier			29c.	License	number	1 4			signed (Monta		
			1. 6al	~ ~				316				10313	100)	
	5		30. Name and address of person who completed and State 12	ed cause of death	(Item 23a) (Type, F	Print)	THE	MAS 1	K- G	And a	10	Ma		
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's										
l <sub>a</sub>	Registra	ar	aug 0 6 2007	A PARIAS.	15 15	RE-EN								

DHMH 17 Rev 1/2001

07-05901 William Johnson

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

illiaiti Johnson		- For State	Cei	tificate of	Death	,	Reg.	No.	HI ROUU
Physici		Registrar 1. Decedent's Name (First, Middle,La	st)				2. Date of Death	av Year	3. Time of Death
edical Exami		William		Johnsor			August 2, 20	007	0210 hrs
		4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or L	ocation of Death		4c. County of De	ath
		St. Agnes Hospital			Baltimore		To D	N A	Distribution (State or
Funeral		Social Security Number 6. S	ex 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1	For	Birthplace (State or reign
Director		216-25-1302	X <sup>M</sup> <sup>2</sup> F 18	Yrs		110010	7-20-1	L989	Country) Md.
	Ì	Usual Residence of Decedent							10d. Inside City Limits
any		10a. State 10b. County		, Town or Locat					1 X Yes 2 No
and show		Md. NA		Baltimo					
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	country?
the N a or tified	[함	2119 Clifton Av	renue		21217	7		USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		as Decedent of Hisp es, specify Cuban,			14. Race - An White, etc	nerican Indian, Black, c.
death or ite	Š	1 X Never Married 2 Marrie	1 Yes 2 X No					- "	271-
after al", o	by		d If Yes, Give Year or Dates:		Yes 2 X No		. I ii ii ii l	Specify: 16b. Kind of Busine	Black
ours satur xam		15. Decedent's Education (Specify	_	16a. Deceder during m	nt's Usual Occupati nost of working life.	on (Give kind of w DO NOT use retir	rork done	Ibb. Kind of busine	55/IIIdusti y
6 172 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Line	employed			NA	
Vithin iene.	Ĕ	llth grade	NA NA	0116		8. Mother's Name	(First, Middle, Ma		
Filed Hyg doth		17. Father's Name (First, Middle, Las	L.	Johns	son, Sr.	Janet	(,	Brown	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	William  19a. Informant's Name/Relationship	- Carrentilli -		g Address (Stree	and Number or F	Rural Route Numb	per, City or Town, S	itate, Zip Code)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygene. 27 is made other than "natural", or items 23a or 28a-f she mante event, the Medical Examiner must be notified at once	F	Janet Brown-Jone			Clifton				1217
P = = = = = = = = = = = = = = = = = = =	-	20a. Method of Disposition		Place of Dispo	sition (Name of cen		Date	20c. Location - Cit	y or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Meinal Hygene Important: If iten 27 is marked other than rinjury or other traumatic event, the Medical rinjury or other traumatic event, the Medical		1 X Burial 2 Cremation 3	Removal from State	crematory or o		8-7	-07	Randall	stown, Md.
Fag ment tant:		4 Donation 5 Other Speci	y:	King Men	Name and Address				
Baltir permit. 1 Departmetimporta		21. Signature of Funeral Service Lic	ensee	\	101 E. No	[4]	arch F.F	I. East	21202
	_	23a. Part I. Enter the disease, or cor	enlications that caused the deat	h. Do not enter	the mode of dying,	such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval
Physician /Medical		failure. List only one cause on	each line.						Between Onset and Death
xamine		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gunshot Wou Due to (or as a consequence						
			h	01).					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):					
<u> </u>	Examine	(Disease or injury that initiated	c. Due to (or as a consequence	-f\'.					
N. P. ansit	Ä	events resulting in death) Last		OI).					
ecu and		UNPENDED	dAMENDED						
60, ate be ex shysician	Medical	U						23d. Date of de	livery
376 ifficate		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		etal death 3	Ectopic pregna	ancy	Month	Day Year
Sox 687 leath certific e attending p	cia	past 12 months?	4 Pregnant at time of	to other to the	Other (Specify)				
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unkno	9OTIKITOWIT				Too Dida	h anna una agataitu	te to the cause of death?
d by		Part II. Other significant condition	s contributing to death but not	resulting in the	underlying cause	given in Part I.			Probably 4 Unknown
, P.C ires that signed	Completed by						4		
ords, w requir	lete	1					24a. Was a autop:	sy prio	re autopsy findings available or to completion of cause of
e law	Ę						perfor		ath? ✓ Yes 2 No
tal Rectian: The	၂ ပိ	25. Was case referred to medical			26.Place	e of Death (Check	only one)		
Vital Rec ysician: The l his certificate l director page	B B	examiner?	Hospital: 1 Inpatient 2	✓ ER/Outpatie	nt 3 DOA	Other: Nursi	ng Home 5	Residence 6	Other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  The law rectificate has been signed by all Director: After this certificate has been signed by the fineral director mase 2 should be dease.	-	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	f tnjury 28c. Inju	ry at Work?		now injury occurred	
Inding Af	<u>.</u>	1 Natural 5 Pendin	Aug 2, 2007	0135 hrs	1	Yes 2 🗸 No	Subject sho	ι	
ivisior or Attendafter death Director:	ig	2 Accident Investig	28e Place of Injury - At	home, farm, str	reet, factory, office	building, etc.	28f. Location (S	Street and Number	or Rural Route Number, City
Div Falor Falor Falor Falor Falor Falor	Certification:	3 Suicide 6 Could a determ		ise / Rowho	use		or Town, S 2402 <b>Marbour</b>	ne Ave., Baltimo	re, Md.
lospi 4 hou funer		29a Certifier	zician: To the hest of my knowle	edge, death occ	curred at the time, o	late and place, an	d due to the caus	e(s) and manner a	s stated.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certification of the Homeral Director. After this certificate has been signed by the attending I of the Funcal Director. After this certificate has been signed by the attending I may the funcal director maps 2 should be detached for uses as I	Medical	(Check only one) 1 Certifying Physical Exami	ner:On the basis of examination	and/or investig	gation, in my opinio	n, death occurred	at the time, date	and place, and due	e to the cause(s)
To To	₹ S	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number OCME		29d. Date signed	(Month, Day, Year)
		11 . 11	11 100		O.C	.M.E.	•	August 2, 20	007
		30. Name and address of person w	ho completed ask a of deat (It	em 23a)					
4	1	Theodore M. King, Jr., I			111 Penn S	treet, Baltimo	re, MD 21201	1	
	State		32 Pentstrar's Sign		1				
Reg		/11/// 1/ /)	2007	I. Go	aske				
			3	4 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician August 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Southern Maryland Hospita Center GCOIGC 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** Days Months 1**⊠**M 2□F 9-40-2888 Director November 22, 1934 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified 1 ☐ Yes 2 No Funeral Director Virginia 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be r oncord Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces:
1 Zi Yes 2 No
If Yes, Give 701 1938
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ŝ ٤ D.C. 20020 hristopher Washington, Street 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ■ Burial 2 □ Cremation 3 Removal from State Glen Allen, Virginia H107 4 ☐ Donation 5 ☐ Other (Specify) awn Memorial Garden 22. Name and Address of Facility
ChiNN Fune
2605 Se. Shir 21. Signature of Funeral Service Licensee SETVIC ral SHITING TEN ARLINGTON V9 beck 23a. Part1. Enter the disease, or complications that mused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as onsequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed' certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Lettifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year)

\ 2

30. Name and add

31. Date filed (Month, Day, Year)

ess of pe

6 2007

Registrar
DHMH 17 Rev 1/2001

2934

who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

AVE

Sel 3-4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 239,25 per me, g8/0.08/03/07dhb

Reg. No.

Reg. No. For E State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Year JEAN RUTH JACKSON 00.50M 21 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE UNION MEMORIAL HOSPITAL BALTIMORE N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 218-32-7493 1 □ M % □ F 72 02/28/1935 MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits show "natural", or items 23a or 28a-f shoredical Examiner must be notified at MD N/A BALTIMORE CITY Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 40TH STREET 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: ģ Specify: BLACK 3 Widowed 4 Divorced Year or Dates: Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DISABLED DISABLED is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental JAMES D. JACKSON MARIA STROTHERS ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19702 Item 27 MICHELLE JACKSON DAUGHTER 12 CAPANO DR., APT. B-6, NEWARK, DE 20a. Method of Disposition OF F 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages Department of important: If Its GARDENS O **X** Burial 2 □ Cremation 3 □ Removal from State ö FAITH 7/26/07 Injury o ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL GARDENS
22. Name and Address of Facility 21. Signature Puneral Service Licensee HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS BALTIMORE, AVE, 23a. Party Enter the dease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia Cause (Final disease or condition Approximate Interval Between Onset and Death ulm onal edema **Physician** 12.41 resulting in death) /Medical Due to (or as a consequence of): Examiner ro Sen 1515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed quad sician and burial-tran Due to (or as a consequence of attending physician for use as the buria Multiple Sclerosis Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2□ No Vital 2 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: dire 1X Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division or this s after death.

I Director: After this d in by the funeral di 27. Manper of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 201 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 0 3 2007

32. Registrar's Signature

05859 omas Milton K	ina	Please Type or Print in Black Indelible I State of Maryland / Department of				ble.	ie kaa
STITUO IVIIILOTT I I	•	1- For State Certificate o			Reg.	No.	h 230
Physicia edical Examir		1. Decedent's Name (First, Middle,Last) Thomas Milton King		M Ju	ate of Death Ionth D Ily 31, 200		3. Time of Death 1403 hrs
		4a. Facility Name (if not institution, give street and number) 20011 New Hampshire Avenue	4b. City, Town, o	or Location of Death		4c. County of Death Montgomery	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye		Date of Birth(	MM/DD/YYYY) 9. Bit	
Director		214-36-9793   1X M 2 F   66 Yr	Months Da	ys Hours Min. D	ec 28	1940 Foreign	ountry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			4	10d. Inside City Limits
rland -f show once	to	MD Montgomery Brinklow	Tank 7 . O. de		140-	Citizen of Wilhard Cour	1 Yes 2 XNo
ith the Maryland 23a or 28a-f show notified at once	Director	10e Street and Number 20011 New Hampshire Avenue	10f. Zip Code 20862			Citizen of What Cou SA	nu y ?
th with tems 23 st be no	Funeral	1 Never Married 2 Married Armed Forces?		ispanic Origin? ( Specify an, Mexican, Puerto Rica		14. Race - Amer White, etc.	ican Indian, Black,
ffer dea		1 Yes 2 No 3 X Widowed 4 Divorced If Yes Give Year	Yes 2 X N	o specify:		Specify: blac	ck
hours a	ted by	during r		ation (Give kind of work e. DO NOT use retired)	done 1	6b. Kind of Business	Industry
036 ithin 72 ne. r than *	Completed		k driver	4		transporta	ation
215-0036 be filed within 7 ntal Hygiene. ked other than ent, the Medica		17. Father's Name (First, Middle, Last) Milton King		18.Mother's Name (Fire Betty Ann		iden Surname)	
Mer mar	To Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailiu		eet and Number or Rural  Rockvill	Route Number		e, Zip Code)
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Dispo	osition (Name of c			20c. Location - City o	Town, State
Baltimore, permit Pages I ar Ocpariment of Hee important: If ite ujury or other tr	ÿ	4 Donation 5 Other Specify: Bushy Pa:	rk Cemet	·		Cooksville	•
Balt permit Departi Import		21. Signature of Funeral Service Licensee  Purp Hough Service Licensee  P	Name and Addre	<sup>ss of Facility</sup> Haigh 195 Sykesvi	t Fune	ral Home &	& Chapel
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying	g, such as cardiac or res	piratory arrest	t, shock, or heart	Approximate Interval Between Onset and
/Medical :aminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Card	diovascular D	isease			Death
	Ļ	Sequentially list conditions, b					
4	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
executed an and all - fransit	I Exa	events resulting in death) Last  Due to (or as a consequence of):  d.	<u> </u>				
O, be exersician a	edical	UNPENDED AMENDED					
ox 68760,	an/M	past 12 months?	Fetal death 3	Ectopic pregnancy		23d. Date of delive Month	ry Day Year
Box 68760, e death certificate be the attending physic ed for use as the burned	Physician/Medi		Other (Specify)				
P.O. Box		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	e given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds, P.C	ted t	Remote Cerebral Infarct			24a. Was an	24b. Were a	utopsy findings available
Vital Records ysician: The law requi this certificate has been director, page 2 should	Completed by				autopsy perform 1 Yes 2	ed? death?	completion of cause of
al R	Be Co	25. Was case referred to medical	26.Pla	ce of Death (Check only			
of Viting Physici	To E	examiner?  Hospital: 1 Inpatient 2 ER/Outpatien  1 ✓ Yes 2 No		Other Nursing Ho		esidence 6 🗸 Othe	er: Scene
on of \ nding Phy tth. r: After the funeral	tion:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of	· · ·	Yes 2 No	i. Describe no	w injury occurred	
Division of Vital Records, total or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, str	eet, factory, office	building, etc. 28f.	Location (Str or Town, Sta		ural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ					
To d withi To d	Medical	2 Medical Examiner: On the basis of examination and/or investige and manner stated.  29b. Signature and title of certifier		nse number		29d. Date signed (M	
		Patricia aronica - Pollohius	0.0	C.M.E.		August 1, 2007	
5		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn 9	Street, Baltimore, N	MD 21201		
•	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	4		2.201		

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

			For State Registrar	State of Marylar		artment of F rtificate of			giene Reg. No.		25000
			Decedent's Name (First, Middle, Las	et)				2. Date of Dea	ath	<u>.</u>	3. Time of Death
П	Physicia		Calvin	L. Keiser				Month August	1, 200	Year	4:52 A <sup>M</sup>
4	/Medic Examin	- 4	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat			inty of Death	
Freez.	. 35	ä	1437 Maryland Ave	nue		Sev	ern		Ann	ne Arur	ndel
16.	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year)	9. Birthp	place (State or Foreign
	Director		218-44-9129	M 2□F 62	Yrs.	Wioning Days	TIOUIS WIII.	Aug 27,			land
	pu ,		Usual Residence of Decedent  10a, State 10b. County	100 0	ty, Town or Lo	ecation		-			0d. Inside City Limits
	anyla shov d at	_								'	1 ☐ Yes 24 ☐ No
	he M 28a-f otifie	Directo	Maryland Anne Aru	ndel	Seve	10f. Zip Code			10a Citizon	of What Cour	**
	with t a or 2 be n					,	, ,				•
	sath is 23	eral	1437 Maryland Ave	nue 12. Was Decedent Ever in U	IS 13	211 Was Decedent of F		inecify Yes or No.		ted Sta	
	item iner	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 🕱 No	10.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		Black, White,	
99	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Spe	ecify: WI	nite
21215-0036	2 hou atura ical E	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	elsin e	16b. Kind o	of Business/In	dustry
215	hin 7 e. an "n Medi	ple	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)	rking			
7	d wit giene er tha	Š	,	1	Com	puter Pro	-				vernment
밀	al Hy sal Hy soth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Sur	name)	
Maryland	Ment Ment arkec aric e	မ	Raymond G.	Keiser			Beat	rice J.	Tanke	rsley	
a	2 shc and is ma		19a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ng Address (Street	and Number or Ri				,
2	and ealth m 27 her tr		Nancy Keiser/wife			Maryland		Severn,			
ore	ges 1 t of H if ite or otl		20a. Method of Disposition 1     Burial 2 □ Cremation 3 □	Hemovai irom State		osition (Name of matory or other pla	1	Date		on - City or To	
altimore,	tant:		4 Donation 5 Other (Specify			dge Mem.		/2007	Elk:	ridge,	Maryland
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	ð	D	2. Name and Addre onaldson	Funeral	Home & C	Cremato	ory, P	.A.
			22a Part Enter the disease or com	nlications that caused the dea		411 Annap				arylan	d 21113 Approximate
			23a. Part Enter the disease, or compand or heart failure. List only Immediate Cause (Final	one cause on each line.	ui. Do not en	er the mode of dyn	ng, such as cardia	c or respiratory at	ilest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Pancreati		Lnoma					Months
	Examiner			Due to (or as a conse	quence or):						
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D.	uted d ansit	m.	Cause (Disease or injury that initiated events	•							
7,0	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a conse	quence of):						
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99	rtifica ng ph as th		IF FEMALE:	- 10-							
Вох	th ce tendii r use	an/	23b. Was decedent pregnant	23c. If yes, outcome pf pregr 1□Live birth 2□Fet		∃Ectopic pregnanc	v		23d.	Date of deliv	
E	w requires that the death certil been signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of 9□Unknown	death 5[	Other (specify)				Month	Day Year
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Ĭ.	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only o			
0	Phys this cal din	မှ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		4 Linursing r	Home St Resid			fy)
NO.	ling F After funer	ion:	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	Injury	Wo	ryat rk?  Yes 2∐No	28d. Describe I	now injury of	ccurrea	
Si	Attending Physician: r death. ector: After this certifics by the funeral director, is	Certification:	2 Accident investigation 3 Suicide 6 Could not be		nome farm st		162 2 140	28f Location (6	Street and N	umber or Rur	al Route Number,
Division or Vital Records,	or A after Direct in by	ifi	4 ☐ Homicide determined	building, etc. (Spec		reet, factory, office		City or Tov		umber of Hum	ai i loute ivallibel,
_	To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1X Certifying Ph	ysician: To the best of my kn	owledge, deat	h occurred at the ti	me, date and plac	e, and due to the	cause(s) and	d manner as s	stated.
	e Ho. e Fur letely	Medical		niner: On the basis of examin and manner stated.							
	To th within To th Somp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
			1	About 6.	mic	D275	13		Aug	gust 2,	2007
,	8		30. Name and andress of person who	completed cause of death (Ite	m 23a) (Type,						
	0		Janice Rutkowski,	M.D. 1215 A	nnapo1:	is Road	Suite 10	7 Odent	on, Ma	arylano	1 21113
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	and o					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Margaret E. 7:55 PM Koesters AUGUST 2007 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Days Hours Min. 213-30-9019 1 □ M 2√2 F 79 Maryland Feb. 21,1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A Baltimore City 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Haubert Street 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White **3** Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Flynn Annie Barret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4531 Taraley Court, Ellicott City MD 21042 19a. Informant's Name/Relationship (Type. Print)
Peggy Gessler / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 8/6/2007 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Streamer of Funeral Service Licensee Victor P. Doda, Jr<sup>22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.</sup> 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO GENIC 6 HOURS Due to (or as a consequence of): CORONARY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Department of Health Important: If item 27 any injury or other the once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f sh notified

"natural", or items 23a or edical Exaπiner must be a

the Medical

...vental Hygiene. 127 is marked other than "n 17 traumatic event".

Pages 1 and 2 should be file ment of Health and Mental Hi ant: If item 27 is marked oth

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Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

The law requires that the death certificate be executed

physician and sthe burial-trans as attending properties for use as ed by the a signed t d be deta cate has by page 2 s certificate this

After t

within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending I 24 hours after death.

10

Be

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Certification:

Medical

Examiner Physician/Medical Completed by

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9□Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Month 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

24a. Was an autopsy performed? Yes 22 No 1□ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Vear

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manper of Death 1 Natural 2 Accident

29b. Signature and title of certifier.

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Iniury 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

MEMORIAL

29a. Certifier (Check only

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

UNION

MA

D41637

29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 0 6 2007 32. Restrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year Eileen Marie Lanham 07/30/2007 1:00 am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4938 Eastwood Ct. Ellicott If Under 1 Year City Howard | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/26/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F 218-12-6649 83 Director MD Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 ☐ No MD Howard Ellicott City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 4938 Eastwood Ct. 21043 HSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other transmatic. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Jubb Stella Hartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lanham / Daughter 4938 Eastwood Ct., Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 08/02/2007 Catonsville, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) Cary I. Kaufman Funeral Home at MMP, INC 7250 Washington Blvd., Elkridge, MD, 21075 of Funeral Service Licensee M01378 flications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a Part Lenter the disease, or shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **CVA Physician** /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ Hypertension 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hyperlipidemia 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred al or Attending Fafter death.

Director: After After Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Victor Madrid, MD -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D58046

29d. Date signed (Month, Day, Year) August 6, 2007

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

32 egistrar's Signature

MD 2105 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM/9 perFH 3870 8/6/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6: 22 AM Lilly Sr. 8 Delandies 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 03 231-30-0199 Hsual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County M∏Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21216 U.S.A. 2830 Clifton Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give\* Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3√2 Widowed 4 □ Divorced Black Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber 9th grade na Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bethel Hair Andrew Lilly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2830 Clifton Ave, Baltimore, Md 21216 Geraldine-Taylor-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/7/07 Arbutus Memorial Arbutus , 21. Signatu March F/H West elof Funeral Service License 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that cau<del>sed the shock, or hear failure.</del> List only one cause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Sepsis day /Medical Due to (or as a consequence of): Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): and Division or Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Alchei Vih 8/3/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Alche Wh E. university play 21218 Daltinere MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For 1 _ State	State of	Marylan	-	irtment of l tificate of	Health and	Mental Hy	7	00	7 25011
tho			Registrar  1. Decedent's Name (First, Middle,	Last)		Cer	incate of	Dealli	2. Date of De	Reg. No.	UU	3. Time of Death
	Physici		Pugana	,	Lesli	0	Lang	horn	Month Augusi	Day - 2	Year	3:15p. <sup>M</sup>
À	/Medio Examin		Eugene 4a. Facility Name (If not institution,	give street and num				or Location of Deat		4c. Coun	ty of Death	
# 			Gilchrist Nur					wson	1			imore
	Funeral			3. Sex 7 1 1 M 2 □ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		(Month, D.	ay, Year)	9. Birth	place (State or Foreign ntry)
R	Director		229-62-4892 Usual Residence of Decedent	Λ	62	110.			05 1	7 45		VA
	yland now at		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	a-f sh	ctor	MD NA		E	Baltin	nore					1 Taves 2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry?
	s 23a	ral	5429 Lynview A		dont Consider 11	0 10 1		1215	N		S.A.	on Indian
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Married ※☐ Marrie</li></ul>	Armed For	2 No	5.   13. V	Yas Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Bl:	ack, White,	
5-0036	al"; or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e	1	☐ Yes 21/X No	Specify:		Spec	rify:	Black
ָבָּ בּ	72 hou natura lical E	ted	15. Decedent's	Education grade completed)		16a. Deced	ent's Usual Occu	pation	rkina	16b. Kind of	Business/In	dustry
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7	led w Hygier her th	ပ်	12th grade	na		Co	nstruc	tion Wo	rker me (First, Middle	1		tion Co.
yland	l be find he ded out	Be	17. Father's Name (First, Middle, Li						•	, Maiden Surna	ine)	
Ž	should nd Me mark matic	은	Edward Langhor  19a, Informant's Name/Relationshi			19b. Mailin	q Address (Stree	Annie		per, City or Tow	n, State, Zij	o Code)
Z	nd 2 saith ar 27 is r trau		Catherine Lang		fe		•	w Ave,				1215
ře,	ss 1 a		20a. Method of Disposition		20b. P	lace of Dispo:	sition (Name of natory or other pla	i	Date	20c. Location		own, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Murial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	I ∐Removal from S ∍cify)	state		Mount	,	/07	Cumb	erla	nd, VA
ă	spartr spartr ports ny Inju		21. Signature of Funeral Service Li	censee	,	22 M <i>ē</i>	Name and Add	ess of Facility H West				
מ	8 4 E 6 9	0. 1	Tyrell	UK-Y	nes	143	300 Wab	ash Ave	, Balt	imore,	Md	21215
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that ca nly one cause on ea	aused the death ach line.	-			c or respiratory	arrest,		Approximate Interval Between Onset and Death
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X R R	death certif e attending d for use as	ian/	23b. Was decedent pregnant in the past 12 months?		irth 2∐Feta ant at time of d	ldeath 3□	Ectopic pregnan Other (specify)	су			Date of deliv Month	ery Day Year
j.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unkno		eatii 5	Other (specify)					
ς, Γ	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant condition	s contributing to de	eath but not resu	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
	quiree in sign	ed by							1 🗆	Yes 2 No	3 ☐ Pro	bably 4 Unknown
ecord	G O O	ompleted							24a. Wa		o. Were auto	opsy findings available ompletion of cause of
Ť	The law ate has page 2 s	E O							perl	opsy ormed? 2 No	death?	2 □ No
VITa	siclan; The li certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?						ath (Check only			
5	Sir D	은	1 ☐ Yes 2 ☑ No			ER/Outpatien	t 3 DOA		Home 5 ☐ Res			to Hospice
	ding Phys h. After this ( funeral dir	jon:	27. Manner of Death  1 ■ Natural 5 ■ Pending		th, Day Year)	28b. Time of Injury	W W	uryat ork? ∃Yes 2⊟No	28d. Describe	how injury occ	urred	V
UIVISION	death death ctor: y the	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be 200 Place	of injury - At ho	ome, farm, str	eet, factory, office		28f. Location	(Street and Nur	nber or Rur	al Route Number,
2	after Dire	Certification:	4 ☐ Homicide determin	ed buildin	ng, etc. (Specif	y)	. ,,			own, State)		,
	ospita hours unera ly fille			Physician: To the								
	the He lin 24 the Fi	Medical	(Check only 2 ☐ Medical E	xaminer: On the ba and mann		and/or in			curred at the time			
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	Σ	29b. Signature and title of certifier	, /	1	0	29c. Licer	nse number		29d. Date sign	ned (Month,	Day, Year)
•			- 41 Hust	my /h	ey,	ny	11	1007		Mugo	A ~1	
	6		30. Name and address of person w	ho completed cause	e of death (Item	n 23a) (Type,	Print) N.	S205 Charle	sSt. t	Balto	md	2,20%
	Sta	ite	31. Date filed (Month, Day, Year)	2007 32. Re	egistrar's Signa	ature	20 "					
	Registi	ar	MUU V V Z	JULY THE	Holland South	337	The same of the sa					

DHMH 17 Rev 1/2001

			For State Registrar	State	of Ma	ryland / [	Depa <i>Cei</i>	artment of H	lealth an Death	d Mer		giene Reg. No.		25015
	Dhyaisi		1. Decedent's Name (First, Midd	lle, Last)							Date of De Month	ath Day	/ Year	3. Time of Death
	Physici /Medic		Edith Lydia Mu							30	3/01/2	2007		7:35 P M
1	Examin		4a. Facility Name (If not institution Arden Courts As	. •				4b. City, Town, or Silver	Spring				ntgome	
	Funeral Director		5. Social Security Number 040-05-6986	6. Sex 1 □ M 2 1 F	7. Age	(In yrs. last bii O	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Bir (Month, Da 2/22/	y, Year)	Co	thplace (State or Foreign ountry)
	and		Usual Residence of Decedent  10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·		10c. City, Tow	n or Lo	cation						10d. Inside City Limits
	Maryl feho	for	MD Balti	more		Phoenix	ζ							1 □ Yes 2 □No
	r 28a	rec	10e. Street and Number					10f. Zip Code				10g. Citi	izen of What Co	ountry?
	th with	al D	2913 Stockton R	oad				21131				USA	Α	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 Is marked other then "neturel", or Items 23a or 28a-f ehow minportent: If item 27 Is marked other then "neturel", or Items 23a or 28a-f ehow appringly or other treatments event, Ite Madical Eventilled in Collical and DOCE.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma  3 ☑ Widowed 4 □ Divorce	If Yes G	orces? 2 🔀 No iive		1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin In, Mexican, P Specify:	? (Specify Puerto Ric	Yes or No an, etc.)	)-	14. Race - Ame Black, Whit Specify: Wh	te, etc.
21215-0036	eture	ed t	15. Decede	nt's Education		16a		lent's Usual Occup				16b. Ki	ind of Business	/Industry
215	hin 72 n "ne Media	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed	) (1-4or 5+	,	(Give life. I	kind of work done of OO NOT use retired	during most of f)	f working				·
21	ygiene /giene /er the	Completed	12				ist						nting	
Maryland	12 should be filed within ? h and Mental Hygiene. 7 Is marked other then " freumetic event, Ire Me.	Be	17. Father's Name (First, Middle						18. Mother's			, Maiden	Sumame)	
Z S	d Mer narke netic	2	William Borcha  19a. Informant's Name/Relation			106	Mailie	g Address (Street	Lydia			or City o	r Tour State	Zin Codo)
Ma	th and the street treet		Nicole Torres		uahte			Stockton						Zip Code)
ē,	s 1 and f Health item 27 other to		20a. Method of Disposition			20b. Place o	f Dispo	sition (Name of natory or other place	1-	Date			cation - City or	Town, State
e E	Pages nent of th nnt: If ite		1 ☑XBurial 2 ☐ Cremation  1 ☐ XBurial 2 ☐ Cremation		State			itional Cem	1	3/31/	2007	Δrli	neton	777
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service		_	, 111114,00	22	. Name and Addres	ss of Facility					
8	P P E E		1 Janil	X	5)		76	eck Fune 01 Sandy	Spring	ne 7 Roa	d, La	urel	, MD 20	707
	Physician		23a Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition			he death. Do ). to Thri		er the mode of dyin	g, such as cai	rdiac or re	spiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		_	consequence								
		er	Sequentially list conditions,	D		Dement			-					
	uted d ansit	Examln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Con	estiv	ve Hear	+ F	ailure						
ó	icate be executed physician and s the burial-transit	Еха	resulting in death) Last			consequence		322020						
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O. Box 6	The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		birth 2 nant at ti	f pregnancy   Fetal death me of death		Ectopic pregnancy Other (specify)					23d. Date of de Month	livery Day Year
Records, P.	quires that n signed b uld be deta	by	Part II. Other significant condit Hypothyroidi:		death but	not resulting i	n the u	nderlying cause giv	en in Part I.					o the cause of death?
00	aw requir is been si 2 should	Completed									24a. Was			utopsy findings available completion of cause of
Ä		E O									autor perfo 1  Yes	ormed?	death?	2 No
Vital	ysicien: This certificate director, pag	Be (	25. Was case referred to medica						26. Place of	Death (C	heck only o	one)		ssisted
of	ding Phys .r After this funeral dir	2	1 ☐ Yes 2X No  27. Manner of Death  1X Natural 5 ☐ Pendi	28a. Date			utpatien Time of Injury	28c. Injur Wor	y at	28d	5 🗌 Resi		6 y ther (Spe	icify) Tiving
Division		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place		y - At home, fa (Specify)	arm, str	eet, factory, office		28f.	Location ( City or To			ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical (	29a. Certifier 1 XCertifyi (Check only one) 2 Medica	ing Physician: To the I Examiner: On the and ma	e best of basis of e nner state	examination ar	e, death nd/or inv	occurred at the tin vestigation, in my o	ne, date and p pinion, death o	olace, and occurred	due to the at the time,	cause(s) date and	and manner as I place, and due	s stated. e to the cause(s)
	To t with To t	Σ	29b. Signature and title of certific	E. VB	Le	e r	1.1	29c. Licens D - 20					st 6, 2	
3	0		30. Name and address of person Kirti Vohra, MI						a MID 2	00217				
	Sta Registr		31. Date filed (Month, Day, Year	6 2007	Registrar	's Signature	So	all!	-, 2	.001/				

DHMH 17 Rev 1/2001

State

Registrar

Balto.

3455, Wilkens

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KO MOUK, Dang M.D., 3455, Wilkens

nth, Day,

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** a<sup>™</sup> 2007 July 31. 6:03 Owen McGlynn, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 1303 Kingsbury Road Owings Mills If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 X M 2 T F Oct 17, 1929 214-24-9791 77 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Owings Mills Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 U.S.A. 1303 Kingsbury Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 32 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 DNever Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 □ Widowed 4 □ Divorced White Vear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Banker Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Owen A. McGlynn, Sr. Elizabeth Kestner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 Kingsbury Road Owings Mills, MD Judith A. McGlynn Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Marys Cemetery 8/3/07 Silver Run, Maryland 21. Signature of Fune al 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at shock, or heart failure. List only one cause on each rije. Approximate Interval Between Onset and Death Immediate Cause (Final 105 **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 3□ DOA ၉ 1 Inpatient 2 ER/Outpatient 5 ■ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 TNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Date signed (Month, Day, Year) 29b. Signature title of certifier icense numbei

21

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 0 6 2007



State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 = For State Registrar	,	_	irtment of H <i>rtificate of L</i>			Reg. No.	117	2501
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/Medical Examiner	4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town, or	Location of Death	July 2	4c. County		0.00 1
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Funeral			n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthpl	ace (State or Foreig
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ylan how at	10a. State 10b. County	10	Oc. City, Town or Loc	cation				10	0d. Inside City Limit
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vith the Mar t or 28a-f st be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Coun	try?
h with	70 Dundalk Av	renue		21222	2		USA		
fer death v r items 23a liner must Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecity Yes or No-	14. Rac	e - America	
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To the Hospital or Attending Physician: The law within 24 hours after theath.  To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2:	25. Was case referred to medical examiner?  1 Yes 2 No  27. Mann of Death  1 Vatural 5 Pending investigat  3 Suicide 6 Could not determine  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Y building, etc. (  Physician: To the best of raminer: On the basis of examiner states	ear) Injury  - At home, farm, structure Specify)  my knowledge, death kamination and/or in-	M 1 □ eet, factory, office n occurred at the fir vestigation, in my o	Yes 2 No	city or Tou	cause(s) and m date and place,	anner as s	tated. the cause(s)

07-05787 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Stuart Mitchell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 28, 2007 1447 hrs Medical Examiner ennet 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Davs Hours Min Director 96 Country) 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c City, Town or Location 10a, State 10b. County Yes 2 M or items 23a or 28a-f show must be notified at once, death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 14. Race - American Indian, Black, Funeral 11. Marjtal Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Himore, MD 21215-0036

The Pages I and 2 should be filed within 72 hours after deartrant of Health and Mental Hygiene retait; If tien 27 is marked other than "matural", or ite or other trannatic event, the Madical" Yes 2 Νo Give Year No Yes 2 specify Specify Divorced Widowed 4 \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DD NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) noth Serpervifair 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 10 M (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b Mailing Address 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD Sister md 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: I injury or othe malor Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Fricility 3405 21229 lace m. disease, or complications that caused the death. Do not enter the mode of bying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Part I. Enter the disease, or complication failure. List only one cause on each line **Physician** /Medical Death Gunshot Wounds with Complications Immediate Caus (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy

The law requires that the death certificate be executed attending physician or use as the burial Box 68760 Records, P.O. certificate has the Hospital or Attending Physician: Division of Vital After Certification: neral Director: / within 24 hours after death. To the Funeral Director:

Physician/Medical ģ Completed Be

To the

Registrar

31. Date filed (Month, Day, Year) AUG O

Pending

Investigation

Could not be

Name and address of person who completed cause of death (Item 23a)

determined

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner egistrar's Signature

Live birth

Unknown

Hospital: 1 / Inpatient 2

28a. Date of Injury

and manner stated

Mar 20, 2007

(Specify) Local Street

g

Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy

26.Place of Death (Check only one)

Nursing Home 5

Subject shot

Other;

Yes 2 ✔ No

28c. Injury at Work's

29c. License number

O.C.M.E.

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Fetal death

5

ER/Outpatient 3

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

0008 hrs

Other (Specify)

Year

Month

24a. Was an

autopsy

performed? ✓ Yes 2

28d. Describe how injury occurred

Residence 6

or Town, State) 2900 Block Mosher Street, Baltimore, MD

July 29, 2007

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 ✓ No 3 Probably 4 Unknown

death?

Other:

1 1

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available

prior to completion of cause of

Signature and title of certifier

Laron Locke MD.

23b. Was decedent pregnant in the

25. Was case referred to medical

1 🗸 Yes

27. Manner of Death

2

3

Medical

Natural

Accident

Suicide

4 V Homicide 29a. Certifier (Check only

1 Yes 2 No 9 Unknown

past 12 months?

)			For State Registrar	State of M	larylar	-	artment of h				ene 007	250	20
			1. Decedent's Name (First, Middle,	Last)					2	. Oate of Death		3. Time of I	Death
П	Physici /Medio		CERESSE		OLIV	ER				Month JULY 3	Day Yea		AM
	Examin		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of		30-1	4c. County of De		
Н			JOHNS HOPKINS	BAYVIEW ME	<b>EDICKL</b>	CENTER	R BA	LTIM	ORE				
	Funeral			3. Sex 7. A		last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day, 13,	(ear) 9. B	irthplace (State or Country)	Foreign
	Director		587-92-5000	1□M 2\\ F	52	Yrs.	Montals Days	Hours	\$e	pt. 13,	1954 M	obile, A	L
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City	Limits
	Aaryla f sho	ō		1 1			32,1011					1 Tyes	
	the t	rect	Maryland Anne A	rundel	Ar	nold	10f. Zip Code			10	g. Citizen of What (	Country?	
	aa or	Funerai Directo	1196 Bunker Aver	1116			21012			13		Journay.	
	ms 2	era	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13. \	Was Decedent of H	dispanic Orig	gin? (Specif	tv Yes or No-	U.S.A.	nerican Indian,	
ထ	or Ital	Fur	1 ☐ Never Married 2 X Marrie	Armed Forces d 1 ☐ Yes 2 ☒		1	t Yes, specify Cub	an, Mexican	n, Puerto Ric	can, etc.)	Black, WI		
21215-0036	ral', c	i by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2X No	Specify:			Specify:	White	
5-0	72 h	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup	during most	t of working	10	Sb. Kind of Busines	s/Industry	
7	vithin ne. han,	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retire	d)					
2	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show avant, I'w Medical Exerting frest be notified at		12 17. Father's Name (First, Middle, L.			Но	memaker	40.44.4			Own H	ome	
and	be f ntal h ed oi	Be	Thomas L. Comer	•							uiden Sumame)		
2	should and Meni marke umatic	ပ	19a. Informant's Name/Relationshi			10h Mailin	Address (Street			lewton	City or Town, State	Zin Cadal	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, If we Medical Exercitive frast be notified at once.		Keith A. Oliver		)		Bunker A					, ZIP C008)	
more,	s 1 ar f Hea item other	1	20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date	-	c. Location - City o	or Town, State	
Ë	Pages nent of H int: If ite		1 🔀 Burial 2 □ Cremation : 1 □ Donation 5 □ Other (Spe		<b>7</b>		Cemeter	1	8/6/00	7 1	ustis, F	r	
5	permit. Departm Importa any inju		21. Signature of Funeral Service Li		GIC	22	. Name and Addre	ss of Facilit	v			L	
_	Pe m m co		X Jenniel	Fillian		H. 3	amlin & l 26 E. Ora	Hilbis ange A	sh Fun	eral Di Eustis.	rectors FL 3272	6	
г			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the deat							Approximate Interval Betw	een
	Physician		Immediate Cause (Final disease or condition	a PULMON	IARY	EMPOL	ISM					Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or a								1 11901	
ŀ.	LAGITIME	_	Sequentially list conditions, if any, leading to immediate	b									
u/	pet nsit	nine	Cause (Disease of Hijery	Due to (or a	s a conseq	uence on:							
V	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):							
8760,	death certificate be executed attending physician and of for use as the burial-transit	dicail		d									
9	tifica ng ph as th												
Box	death certifica attending ph d for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnancy	,			23d. Date of d		
O.	at the dea by the at tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (specify)				Month	Day Ye	ear
<u>a</u> :	hat th id by setacl		Part II. Other significant condition	e contributing to death	but not con	ulting in the	dochina asses as	an in Danil		220 Did tobo	cco use contribute	to the source of do	-1h-2
Vital Records,	The taw requires that the te has been signed by the bage 2 should be detache	d by	ADRENAL INSUFFI				ESS POLYI			1 ☐ Yes		Probably 4 Dur	
20	w require been si should I	ete			HOLE	TECNE	253 10011	100000	11.	-			
Re	: The taw cate has page 2 s	Completed	OSESITY							24a. Was an autopsy performe	prior to	autopsy findings av completion of car	
ā			25. Was case referred to medical					00 51	-(5	performe	No 1□Ye	es 2 No	
	Physician: this certifice ral director, p	To Be	examiner?	Hospital: 1 ☐ Inpati	ent 2 🗙	ER/Outpatien	t 3□ DOA Oth	00		heck only one)	ce 6 ☐ Other (Sp	noife)	
IVISION OF	g Ph		27. Manner of Death	28a. Date of Inj	ury	28b. Time of Injury	28c. Injur Wor			I. Describe how		ecity)	
jo	andin ath. or: Afi	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	ly rour,	inquity		Yes 2 N	No				
Š	ial or Attanding Physician: s after death. al Director: After this certification by the funeral director.	ertification	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of in	jury - At ho tc. (Specify	ome, farm, stre	eet, factory, office		28f.	Location (Stre City or Town,	et and Number or I State)	Rural Route Numb	er,
	urs af urs af sral D	O											
	Hosi 24 ho Fune stely f	edicai	29a. Certifier (Check only one) (Check only one)	Physician: To the best aminer: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred at the tir estigation, in my o	ne, date and pinion, deat	d place, and th occurred	due to the cau at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)	
	To tha Hospital or within 24 hours after To the Funeral Dire completely filled in E	Mec	29b. Signature and title of certifier	and manner s	ateu.		29c. Licens	e number		290	. Date signed (Mor	nth, Day, Year)	
	r s r ó		1 Junta.	Handa	MID		7/-	2032				200=	)
	10		30. Name and address of person wi	no completed cause of	death (Item	23a) (Tvne I		JU 32		) (	JLY 30	200-	
	10			BAYVIEW C	IRCL	E BA	LTIMORE	MI	21:	224			
	Sta	_	31. Date filed (Month, Day Year)	32 Regist	rar's Signa	ure		4		1			
	Registra	ar	AUG 0 6	LUU1	یگر م	P ASSE							

			1 - State Amend Items 25,28a-f	laryland / Depa ,23a,PtI pe	artment of Health in 1987 (1987) Time 2870 087 (1987) Tiflicate of Death	and Mental Hy <b>3/0/dhb</b>	giene Reg. No. 2   1   7	25021
*	le e	3	Decedent's Name (First, Middle, Last)		00.	2. Date of De Month	_	3. Time of Death
	Physici /Medic		Jern		)+tut	July	18 2007	1050 PM
	Examin	er	4a. Facility Name (If not institution, give street and number HOSD: TO!	7)	4b. City, Town, or Location		4c. County of Death	
	Funeral Director			ge (In yrs. last birthday) 59 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bin Min. (Month, Da Mar 23	v, Year) Cour	olace (State or Foreign ntry) unk
	pug .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits
	faryla shoved at	or	MD	Baltimo				1√∑Yes 2 No
	the N 28a-1	Director	10e. Street and Number	Dareimo	10f. Zip Code		10g. Citizen of What Cour	ntry?
	3a or	Ö	601 S. Charles Street #360	าย	21230		USA	,
	death ms 2;	Funeral			Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? (Specify Yes or No		
980	72 hours after death with the Marylan "natural", or items 23a or 28a-f show idical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes, Give 1 Widowed 4 Divorced Year or Dates	] No	If Yes, specify Cuban, Mexica  1 ☐ Yes 2 【 No Specify:		_	etc. iite
21215-0036	⊆ ~ Ψ	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working unk	16b. Kind of Business/Ind	dustry unk
121	e filed withing Hygiene.  other than yent, the M		unk unk  17. Father's Name (First, Middle, Last)		18 Moth	er's Name <i>(First, Middle,</i>	Maidan Surnama)	1
lanc	be ad of the seven ever	To Be	17.1 alifet 3 Name (First, Middle, Last)		unk 18. Moth	a a wame (i iiat, imuule,	, Maiden Surname)	unk
Maryland	nd 2 shaith and 27 is m	-	19a. Informant's Name/Relationship (Type. Print) Harbor Hospital	l l	ng Address <i>(Street and Numb</i>			Code)
Baltimore,	of of the second		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 ★ Other (Specify) in Stat	9	osition (Name of matory or other place)	Date	20c. Location - City or To	wn, State
Balti	permit. Pag Department Important: I any injury o		21. Schatur Funeral Structicensee S. Hade Din	ector Si	2. Name and Address of Facilitate Anatomy Baltimore, MD	oard 655 W. 21201	Baltimore S	treet
			23a. Part Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Chuse (Final disease or condition resulting in death)	s a consequence f):	cardial 7	ntavetor	1	Hour
16	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of):	Brain	FRIAN	EVAMINER .	7 mintri
68760,	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last Due to (or a	s a consequence of):	CERTIFICAT	ION APPROVED BY MEDIA	ALGOV	
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Mec		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
ds, P.O.	uires that I signed by Id be deta	þ	Part II. Other significant conditions contributing to death	-	nderlying cause given in Part		cobacco use contribute to the	
Vital Records,	re law requ has been ge 2 shoul	Completed	Diabetes			24a. Was	psy prior to co	psy findings available mpletion of cause of
a F						pend 1⊟ Yes	ormed? death? 2 No 1 Yes	2 No
Κ		Be	25. Was case referred to medical examiner?  1 Teyes 2500 Hospital: 1 Inna		Other:	e of Death (Check only o		
o		- T	1 Trospital 1 Inpa  27. Manner of Death 28a. Date of In		IL SLI DOA   4LIN		dence 6 Other (Specification of the following description of the following	<i>y)</i>
on	Attending Ph r death. ector: After th by the funeral	tior	1 □ Natural 5 □ Pending (Month, D 2 ☑ Accident investigation 12/27/2			No Subject	pedestrian s	struck by
Division	or Attend after death. Director: / in by the fu	ertification:	3 Suicide 6 Could not be 28e. Place of in	njury - At home, farm, stretc. (Specify)		28f. Location City or To Gude Dr	of Street and Number or Rura In, State) Lye at Rothgo	A Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manner: and manner	t of my knowledge, deat of examination and/or in	h occurred at the time, date a vestigation, in my opinion, de	nd place, and due to the	cause(s) and manner as s	tated.
	To the within To the Comple	Mec	1 and marrier		29c. License number		29d. Date signed (Month,	Day, Year)
			> Bulling / / Z-		1)3854	3	July 18,	2007
			30. Name and address of person who completed cause of 3001 50 in the Itamov	death (Item 23a) (Type,	29c. License number D3854 Print) Balfis	rore, Ma	ryland ?	21225
a,	Sta Registr	- 1	31. Date filed (Month, Day, Year)  AUG 0 3 2007	trar's Signature	E)			

DHMH 17 Rev 1/2001

			For State Registrar	State of M	arylan		artment c rtificate (			Mental H		7 1111	7 2	5022
		7	Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death									Time of Death		
-	Physici /Medic		Allan M. Ostrow							Augus	t 2,	<sup>2007</sup> 2007	4:	22 A. M
	Examir		4a. Facility Name (If not institution, g	give street and number)			4b. City, Tov	n, or Loca	tion of Death		4	4c. County of Death		
		TA	Shady Grove Adve				Rockv					Montgon		
	Funeral Director		578-42-3092	5. Sex 7. Aç 1 🖾 M 2 🗆 F	76	last birthday) Yrs.	If Under 1 Y Months Da	ays Ho	nder 24 Hrs. urs Min.	8. Date of E (Month, I Jan. 6	Day, Yea	9. 31 Ca	Birthplace ( Country) Lifor:	State or Foreign
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-					10d. in:	side City Limits
	Mary a-f sh fied a	tor	Maryland Montgom	erv	Roc	kville							1 1	XYes 2 No
	th the or 28¢	Director	10e. Street and Number		1		10f. Zip Co	de			10g. C	Citizen of What	Country?	
	ath w		504 Linthicum St				2085					ted Sta		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show wanty injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	Narital Status     Never Married 2☑ Married     Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 ⊠ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	Vas Decedent f Yes, specify ☐ Yes 2[X]		c Origin? (Sp xican, Puert ecify:	pecify Yes or I p Rican, etc.)	No-	14. Race - A Black, W Specify: W	hite, etc.	ian,
ş	2 hou atura	ted	15. Decedent's	Education	KOLE	16a. Deced	lent's Usual O	cupation			16b.	Kind of Busine		
21215-0036	d within 7/ giene. r than "n the Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	(Give kind of work done during most of working life. DO NOT use retired)  College (1-4or 5+)  5+  Guidance Counselor  Wontgomery Public Sch							Coun	ity		
nd	tal Hy tal Hy tal othe svent,	Be C	17. Father's Name (First, Middle, La	st)						e (First, Midd		,		
Maryland	iould t Ment narked	2	o Samuel Ostrow Bertha UNAVAILABLE											
<u>a</u>	d2sh thanc 7isn		19a. Informant's Name/Relationship Margaret E. Ostr									or Town, Stateryland		
	s 1 an f Heal item 2 other	-	20a. Method of Disposition	Ow / WILE	20b. P		sition (Name o		i	Date		Location - City		
Ë	Pages nent o nt: If i		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1		rematori rematori			st 5, 07	Bet	hesda,	Marv1	and
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service Lic	ensee		Rot	Name and Accept A. I	dress of F	acility Ev Fune	cal Home,	/Rock	ville. I	nc.	350-2805
	2015		23a. Part1. Enter the discuse, or conshock, or hear the ure. List on	omplications that cause								1110, 1	Appr	oximate
	Physician /Medical		shock, or hear the rue. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Acute Myocardial Infarction  Due to (or as a consequence of):											
	Examiner		Sequentially list conditions	, Congest			Failure	<u> </u>					mont	hs
	pe tis	iner	Sequentially list conditions, if any, leading to in incidate cause. Enter Underlying Cause (Disease or injury	iano of):	ÿ-									
9	xecution and al-tran	Examine	that initiated events resulting in death) Last	uence of):	-									
8/60,	cate be executed physician and the burial-transit	dical		q		•								
O		Medi	IE EEMALE.											
7. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregna Other (specif)					23d. Date of Month	delivery Day	Year
٦	hat the		9 ☐ Unknown  Part II. Other significant conditions		ut not recu	ulting in the un	dorlying agus	civon in B	out I	220 Die	1 tobosoo	use contribute	4 - 4b	
coras,	requires that the	ted by				anding in the un	derrying cause	givenin	are 1.	11				4 <b>X</b> Unknown
Ū L	The lar	Completed	1							24a. Wa aut per 1∏ Yes	opsy formed?	prior	o completic	edings available on of cause of
N La	Physiclan: this certific	Be	25. Was case referred to medical examiner?						Place of Deat	h (Check only				
0	Physic ral dire	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatient	3 DOY		Nursing Ho			6 □Other (S	pecify)	
	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending	(Month, Da		28b. Time of Injury		njury at Work? I □ Yes :	2 🗆 No	28d. Describe	e how inj	ury occurred		
200	Atten r deat ector: by the	fica	3 Suicide 6 Could not	be 28e. Place of inju					20110	28f. Location	(Street a	and Number or	Rural Route	e Number,
5	tal or rs afte al Dir	Certification:	4 Homicide determined building, etc. (Specify)							own, Sta	n, State)			
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1   1   Certifying I  2   Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examinat	wledge, death tion and/or inv	occurred at the estigation, in r	e time, dat ny opinion,	te and place, death occu	and due to the red at the time	e cause( e, date a	s) and manner nd place, and o	as stated. lue to the c	ause(s)
	To the within comp	ž	29b. Signature and title of certifier	7^			29c. Lic	ense numb	per		29d. D	ate signed (Mo	nth, Day, Y	'ear)
	141		THE STATE OF THE S	- 18. U.			D.	370	24		All	164ST	2.0	1007
ĺ	5+1	4	30. Name and address of person wh				r <sub>int)</sub> 1 Cente	Tr Dr	Poo	kw411.			1	
	Sta	te	31. Date filed (Month, Day, Year)	, M.D., 32. Registra			T Cellice	T DE	· , KOC	varite	ענויו פ	20030		
	Registra		AUG 0 6	2007	and A	K Sol	sell							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryante De Daris 1871 of Health affd Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY **Physician** 17:07 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (ld 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 031-20-1405 **Director** July 1, 1930 Rhode Island Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director 1√TYes 2 No Bristol MA Rehoboth 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Reynolds Avenue Funeral 02769 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 Is marked other th 12 Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Hebert Dora Pepin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any Injury or other trau once, Glenn J. Pina /Son 326 Plain St., Marshfield, MA 20b. Place of Disposition (Name of cemetery crematory or other place)
North Purchase
Crematory 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8-2-07 Attleboro, MA 21. Signe ture of Funeral Service Licensee 22. Name and Address of Facility Dyer-Lake Funeral Home 161 Commonwealth Avenue, North Attleboro, MA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 DAY /Medical CONONARY ARTERY DISEASE Due to (or as a consequence of): **Examiner** sequentially fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed attending physician and for use as the buriat-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Veath 28a. Date Miniury 28h Time of 28d. Describe how injury occurred Medical Certification: After or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number OR JONATHAN DATH

DHMH 17 Rev 1/2001

State

Registrar

600

WOLFE ST

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BATH

32. Firstrar's Signature

SONATHAN

6

AUG 0

DK.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 Charles Palmer 12:09 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Canter Randallstown Age (In yrs. 8. Date of Birth (Month, Day, Year) 11 M 2 □ F 64 216-36-3720 3, 1942 Maryland Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 □Yes 2√ No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 942 Shirley Manor Road 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11, Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates; 1 ☐ Never Married 2x Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Joseph A. Banks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wade Palmer Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 942 Shirley Manor Road Regina M. Palmer Wife Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Carroll Cremation 7/30/07 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility 11824 Reisterstown Road stepher M entens ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pure to (or as a consequence 1): DVT- 1 Over extrant BILLITERA Sequentially list conditions. Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) a I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Open cholecy yetomy with 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Acuk Kenal tailune 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-trar the attending pl page 2 certificate director this

After

s after dec... erai Director: A\*... v filled in by the

completely

within 24 hours a To the Funerai I

or Attending

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 2☐ No 27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Road Randa 115 town, My 21133

29a. Certifier (Check only one)

2 Accident 3 Suicide

4 ☐ Homicide

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

256632

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee-bardic AUG 0 6 5 101 legistrar's Signature

010 COUNT

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Physician MARIE ELAINE PICA AUGUST 2007 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1306 GIBBS COURT HARFORD BEL AIR If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 212-48-7392 58 Director 10/2/1948 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 1 XYes 2 No Director FI. SARASOTA NORTH PORT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours atter death with annt of Health and Mental Hygiene. The till fiew T2 is marked other than "naturat", or items 23a or rang yor other traumatic event, the Medical Examiner must be or ury or other traumatic event, the Medical Examiner must be or USA 2463 ALTOONA AVENUE 34286 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 X No Specify: \$ Specify: 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH\_GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PERRY WATSON P RUBY LATHROP 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. MALISA BAGINSKI/DAUGHTER 1334 SALONICA PLACE BEL AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY. INC. 8/4/2007 CATONSVILLE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STRUKE 2 MUNTY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEMLS. LA AMOUTENSING TENORWINSLULUM DISEASE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tran Due to (or as a consequence of). Physician/Medical the attending for use as IF FEMALE: N 7 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Year 5 Other (specify) ed by the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) SISTER'S RESIDENCE 6 Kother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 | Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death

Director: filled in I

the Maryland

Baltimore, Maryland 21215-0036

1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) D15135 ANGUIST 7, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PENERUPE P. SLOTT MD 5601 LOCA RIVEN AWD SOLTMONE, MID 21234

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 0 6



e Funeral

To the Hosl within 24 ho To the Fun completely t

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08/03/2007 Physician Donald Peterson Raynor 8:57 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6916 Kilrain Ct. Columbia Howard If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 579-50-3511 1 M 2 ☐ F Months Days Hours Min 69 02/25/1938 Director Washington, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location show 10a State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Exeminer must be notified at Director 1 ☐Yes 2☐No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6916 Kilrain Ct. 21.045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify. Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4+ Elementary/Secondary (0-12) Project Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumattc event Clinton Raynor Dorothv Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Raynor / Wife 6916 Kilrain Ct., Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park | 08/09/2007 4 □ Donation 5 □ Other (Specify) Elkridge, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC.
Flkridge, MD 21075 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, MD 23 Part1. Errier the dise the shock or heart failure. s that cansed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1⊟ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the I within 24 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Clarhsulle 5005 Abdo ranal 32. Registrar's Signature 31. Date filed (Month, Day, Registrar

DHMH 17 Rev 1/2001

			1 - For Amend Item 2 1 - State Registrar	29State of Ma per dvr	ryland / g870,0	Benartment of l 8706/07dhb Certificate of	lealth and N Death	Mental Hyg	giene 10g. No. 2007	25027		
	Physici	20	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	ith Day Year	3. Time of Death		
	/Medic		Gale Ann Roberts					July 2		11:30 AM		
7	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th		
			602 Stans Road  5. Social Security Number 6. S	2 A A G	(In yrs. last b	Jop oirthday) If Under 1 Year		8. Date of Birth		ford		
	Funeral Director		546-84-6928	□ M 2∏F	56	Yrs. Months Days	Hours Min.	June 27	r. Year) C	thplace (State or Foreign ountry) ifornia		
	and w		Usuel Residence of Decedent  10a, State 10b, County		10c. City. To	wn or Location				10d. Inside City Limits		
	f sho	5	MD Harfo	rd	•	Joppa						
	the north	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C			
	h with		602 Stans Road				21085		USA			
	eme	ner	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S.	13. Was Decedent of H		pecify Yes or No-	14. Race - Am			
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Iteme 23s or 28s-f show the Madical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 N If Yes, Give Year or Dates:	0	1 □ Yes 2X No	Specify:	, , , , , , ,	Specify: wh			
2-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra		16	a. Decedent's Usual Occup (Give kind of work done	during most of work	ung	16b. Kind of Business	/Industry		
12	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use retire cafeteria wo	,		food			
Q 7	Hygir Hygir ther ant,	ပိ	17. Father's Name (First, Middle, Last)			careceria wo		ne (First, Middle,	food  Maiden Sumame)	-,		
au	id be ental ked c	То Ве	Ronald Wilbur Lud	wick			Elaine	Carol W	lilliams			
Maryland	shou and M mar umat	<u> </u>	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailing Address (Street	and Number or Rur	ral Route Numbe	r, City or Town, State,	Zip Code)		
Σ	and 2 saith a n 27 ii		Terry Hill/siste	r		602 Stans Ro	ad Joppa,	MD 210	)85			
altimore,	Pages 1. ent of He nt: If Iten ry or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 ☒ Donation 5 □ Qther (Specify		20b. Place cemet	of Disposition (Name of ery, crematory or other pla		Date	20c. Location - City or	Town, State		
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Bright-ords: If Item 27 is marked other than "naturel; or Iteme 23e or 28e-f show eny injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature Euneral Struice Licen	/ 1	ctor				Baltimore	Street		
			23a. Part I. Enter the disease, or com	plications that caused	0 1	,	ng, such as cardiac	or respiratory arr	rest,	Approximate		
	Pnysician		Immediate Cause (Final Onset and Death									
	/Medical		resulting in death)  Due to (or as a consequence of):									
	Examiner		Sequentially list conditions, b.									
		Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or Injury									
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8760,	ficate be executed physicien and s the burial-transit	dical	(	d	-							
Φ	ertific ding p	Mec	IF FEMALE:	02- Muse	4							
.O. Box	that the death certifi ed by the ettending detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1 1 4 □ Pregnant at 1 9 □ Unknown	23d. Date of de Month							
<u>.</u>	that it ed by detac	F.	Part II. Other significant conditions c	ontributing to death bu	t not resulting	in the underlying cause on	ven in Part I.	23e, Did to	bacco use contribute t	o the cause of death?		
rds,	The law requires that the ate has been signed by the bage 2 should be detached.					124	es 2 No 3 P	Iffornia  10d. Inside City Limits 1				
မင္ပ	hasbe	Completed						24a. Was a autops	an 24b. Were a	utopsy findings available completion of cause of		
<u> </u>		Con						perfor	med? death?			
ZI Z	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat	th (Check only or	7e)			
ō	Phys this ral dir	٦.	1 Yes 2 No  27. Manner of Death	1 Inpatier			4 🗆 Ivursing no		ence 6 Other (Spe ow injury occurred	ecify)		
o	ding Ph th. : After th : funeral	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Work? 1 Natural 5 Pending (Month, Day Year) 28b. Time of Unjury at Work? 1 Yes 2 No									
Division of Vital Records,	I or Attending Physicien: after death. Director: After this certifica in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		ry - At home, (Specify)	farm, street, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,		
	Hospital 4 hours Funerel ely filled	Medical Ce	29a. Certifier  (Check only (C									
	To the Vithin 2. To the Complet	Med	one) 29b. Signature and title of certifier	and manner sta	ted.	29c. Licens	se number		29d. Date signed (Mon	th Day Yearl		
	F ≥ F 8	W.	b and this or some	Dur		17	27/DS	74841	7/2	7/07		
			30. Name and address of person who	completed cause of de	eath (Item 23a	) (Type, Print)	· •	N 1	1	10 :21237		
			HISHKAN C	ANTAN	11/10	J.D. 911-	1 Mil	lAdel	Phia Ko	KAHO, MK		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature				\	,		
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υHΝ	MH 17 Rev 1/20	101		-	16	ORIGINAL						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician Month** 30 05:30 pM 2007 Robins Glenn /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral X**□M 2□F 55 MD Director 214-56-9648 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> Y⊒Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3302 Sumter Ave 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1. Yes 2 No IFYes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Specify: Black 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse <u>12th grade</u> Fork Lift Driver permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any flujury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ပ Marian Haley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 Sumter Ave, Baltimore, Keia Robins-Daughter Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify) Metro Crematory Inc 8/6/07 Baltimore, Md 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lnra Crania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has b autopsy performed 25 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No the Funeral Director; apletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 P 29b. Signature and title of certifier 29c. License number

3+1

RORINS

Glenn

Patient

State Registrar 31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nilleu

MD

32. Registrar's Signature

Sihai

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** a M 4 2007 2:10 August VERNA L. RICH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5800 WINNER AVENUE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Yrs VIRGINIA 86 JUNE 18 1921 Director 217-22-5903 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√TXYes 2 □ No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5800 WINNER AVENUE U.S.A. Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BLACK Specify Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade BEAUTICIAN SELF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CORNELIUS HOOPER ပ CORNELIA JORDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar important: if item 27 is any injury or other trau Vista E. Paige/Niece 5800 Winner Avenue, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) ZION CEMETERY 08-10-07 LOTTSBURG, VIRGINIA 21. Signature 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE, BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ehydrat **Physician** /Medical Due to (or as a consequence of): Examiner D51 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner infections (pressure ulcer) The law requires that the death certificate be executed burial-transit Wound Due to (or as a consequence of): Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Preumonia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No n 24 hours after death.

The Funeral Director: A pletely filled in by the fi death. 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number AHENdiNa

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

State

AUG 0 6 Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SCHWART M.D. 32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

3512

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2:40 p 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** <sup>Year</sup> 2007 Albina Frances Rockhold Aug /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Nursing and Rehab Howard Ellicott City 8. Date of Birth (Month, Day, Year) Feb 28, 1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland Director 90 214-01-1914 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA N Ridge Rd #412 21043 3100 Funeral Items 2 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner enes. 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Clerk Social Security Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Maxa Mary Janda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10217 Clubhouse Ct. Ellicott City, MD 21042 Dale K. Oaks/ nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 8/4/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 1000 1044 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENGESTIVE HEART /Medical Due to (or as a consequence of): Examiner HRONIC RENAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Year Month 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🖰 (lo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 X No 1□ Yes **Division or Vital** To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? i Director: After the in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours eft

To the Funeral Di

completely filled in 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of contifie 29c. License number 29d. Date signed (Month, Day, Year) D0063501 MEDICAL DOCTOR

State Registrar

DHMH 17 Rev 1/2001

405 FREDERICK

ROAD

CATONSVILLE MD21238

address of person who completed cause of death (Item 23a) (Type, Print)

MID

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 **Physician** August 2, 4:45 A. M James V. Ryan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) October 19, 1922 Illinois If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F 84 357-16-4117 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show 1 ☐ Yes 2K No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20854-2706 10817 Old Coach Road Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ tal Hygiene. Elementary/Secondary (0-12) U.S. Government Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Francis Ryan Anne Rose Lahey မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard K. Ryan / Son 22041 Victoria Circle, Great Mills, MD 20634 Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 timor 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cemetery Oct. 17, 2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dis shock, or hear fail-Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lymphocytic Wronic disease or condition resulting in death) /Medical Due to (or as a consequence f): **Examiner** Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence or) Physician/Medical Examiner Septicemia or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Simple4 IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed bage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 15 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier i 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) the 29b. Signature and while of certifier 29c. License number 29d. Date signed (Month, Day, Year) 107 3 D0061302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 0 6 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year atrick 9:00 AM AUG 03 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 60 New York April 6,1947 096-36-0147 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. int: If tien 27 is marked other than "natural", or items 23a or 28a-f show Int: If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9104 Town and Country Blvd. #F 21043 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No δ Specify: 3 ☐ Widowed 4 A Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Administrator Juvenile Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. Smith ို Fannie Pippins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr. once. Erika R. Smith (Daughter) 1830 Bryant Street NE Washington, DC 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specific) Maryland National Cem 8-8-2007 Laurel, Maryland 21. Signature of Funeral Service Licenses 22.Name and Address of Facility Witzke Funeral Homes, Inc. Wille 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, a complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic **Physician** en caphal day /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Moibre 000 burial-tran Due to (or as a consequence of): physician the attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown tate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Did hour prior Smoking history 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1☐ Yes 2☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

AUG

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

139681

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AUG 03,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrixed parking Columbia MD 21044 A Valenti MD 11085 little Stephen

31. Date filed (Month, Day, Year)

32. Régistrar's Signature 0 6

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Year 0340AM Henry Bracev Smith 1014 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 14 34 Hospi Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1⊠M 2□F 72 MS 425-52-0895 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TyYes 2 □ No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3502 7 Mile Lane 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Y⊟Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12th grade Midtowne Medical Pathologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burton Smith Susie Boclair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Stable Run Court, Randallstown, Md 21133 Alva M. Smith-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/6/2007 Crematory Inc Baltimore, Md Metro 21. Sig atule of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part. Enter the usease, or complications that call so the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear distinct. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ptic Shoc dain Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? Yes 2 No 1 ☐ Yes 2 😘 Yo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Menpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

Records, P.O. Box 68760. attending physician for use as the buria Division or Vital

Examiner Physician/Medical

Physician

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

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Medical

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Completed

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death with the Maryland

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Pages 1 and 2 should

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Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

Maryland

Baltimore,

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

2 Completed P Certification:

cal

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

HOSPi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vanu

Y0900, MD 32 Registrar's Signature

31. Date filed (Month, Day, Year)

eding Summe	r	State of Maryland / De	partment of Certificate of		Mental Hy		g. No.	07 2500		
Physici ledical Exami		Decedent's Name (First, Middle,Last)     Reding	Sum			2. Date of Death Month July 29, 20	Day Year	3. Time of Death 1727 hrs		
		Facility Name (if not institution, give street and number)     1327 Valley Street	4	b. City, Town, or L Baltimore	ocation of Death		4c. County of E	Death		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr 219–52–5292 1X M 2 F	rs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birtl	F	Birthplace (State or oreign Country) Md.		
e Maryland or 28a-f show any fied at once.	Director	Usual Residence of Decedent  10a. State 10b. County 10c. C  Md NA  10e. Street and Number	City, Town or Location Balti			10	ng. Citizen of What	10d. Inside City Limits 1 X Yes 2 No Country?		
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiers and the Health and Mental Hygiers and the Health and Mental Hygiers are than "natural", or items 23a or 28a-f she use. If item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	by Funeral	1327 Valley Street  11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No. 3 X Widowed 4 Divorced of Yes, Give Year or Dates:	o If Ye	es, specify Cuban, Yes 2 X No	panic Origin? (Spe Mexican, Puerto F specify:	Rican, etc.)	White, e	merican Indian, Black, tc. Black		
5-0036 Iled within 72 hour. Hygiene. I other than "natu	Completed	15. Decedent's Education (Specify only highest grade completed  Elementary/Secondary (0-12) College (1-4 or 5+)  11th grade NA  17. Father's Name (First, Middle, Last)	during mo	ist of working life. I <b>lass</b> all Warel	on (Give kind of wo DO NOT use retire houseman 8. Mother's Name (	ed)		a Brothers		
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.			Db. Place of Disposi crematory or oth Mt. Zion	tion (Name of cemer place)  Cem. ame and Address of	etery, 8–8-	-07	timore, M 20c. Location - Ci Lansdow .H. East imore, Mc	ry or Town, State		
Physician /Medical Examiner	3 175	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence)	eath. Do not enter th	e mode of dying, s	such as cardiac or i	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death		
executed an and al - transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discose of injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.								
be be	Physician/Medical	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  23c. If yes, outcome of principle in the past 12 months?  1 Unknown  23c. If yes, outcome of principle in the past 12 months?  1 Unknown	regnancy 2 Fet	O,8/7/07,W al death 3 er (Specify)	Ectopic pregnand	су	23d. Date of del Month	ivery Day Year		
Records, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the t	Completed by PI	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause giv	ven in Part I.		2 No 3 24b. Wer prior deaf	re autopsy findings available r to completion of cause of		
Division of Vital Records, road or Attending Physician: The law requires after death.  al Director: After this certificate has been so led in by the funeral director, page 2 should be	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending (Month: Day,Year) 2 Accident Investigation 2 Jul 29, 2007	ER/Outpatient  28b. Time of In FOUND: 1650 hrs	3 DOA O	at Work? 2	Home 5 F	Residence 6 🗸 0 ow injury occurred ged self	Other: Scene		
Division  To the Hospital or Attentwithin 24 hours after death To the Fineral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1327 Valley Street, Baltimore, MD								
To the II within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the best of my known one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier			death occurred at t		. ,	(Month, Day, Year)		
10		30. Name and address of person who completed cause of death (It Jack Titus MD. Deputy Chief Medical Examir	ner 111 Peni	n Street, Baltir	more, MD 212	01				
St Regist	ate rar	31. Date filed (Month, Pay Year) 6 2007 32. Registrar's Sign	nature	NE)	<u></u>					
DHMH 17 Rev 1/20	001	<i>y</i>	ORIGINAL				****			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #1, perMD, g875, 1/28/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BESSIE STEWART Bessie Steward AUG. 2007 /Medical 8:40A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1405 BROENING HIGHWAY N/A BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 219 40 5167 91 Director 30,1916 VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1405 BROENING HIGHWAY 23a 21224 death v USA Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 9 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify. Specify: BLACK W☐Widowed 4☐Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. the 8TH DOMESTIC PRIVATE HOME marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE COLEMAN ပ ELVINE WILSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07 Department of Health as Important: if Item 27 is any injury or other trauonce. GRACE STEWART (daughter) 1310 KENHILL AVE. BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State AUG.7,2007 1 █ Burial 2 □ Cremation 3 □ Removal from State Donation 5 ☐ Other (Specify) MARYLAND NATL.MEM.PK. LAUREL, MD. ignature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO MD. 2121 23a. Part1. Enter the disease, or complications that caused the 2 all 1 shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OYONAKU disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions. Divid to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Physician/Medical the phy as IE FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĺ in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 2000 1∐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) To Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Kesidence 6 □Other (Specify) 27. Manner of Death 28h Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760

Hospital or Attending Physician: After s after uc. rat Director: Att within 24 hours a To the Funeral I

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) AUG 0 6

327 Registrar's Signature

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completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 2:45 A.M HUEN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Decker HUCKUC 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2KF 214-12-8956 Usual Residence of Decedent 83 Yrs. Director LATY/AND permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exa<u>miner must be notifiled at</u> BAHIMERC 1 K Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21265 W.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> Specify: Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OUN TOMERAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCPL HONORAH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Avenue 10CCO Decker BAltimore, MDZ1224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State AKLAWN enetery Aug 8 20 07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licenses 22. Name and Address of Pacility House bino Conklins St BAItO 23a. Part1. Sa shock, complications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, only one cause on each line. Approxima e Interval Between Onset and Death art ilure. Immediate Cause (Final disease or condition resulting in death) **Physician** Same /Medical Due to (or as a consequence of): Examiner pert 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for is a consequence of) Examiner Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 3 Probably 4 ∃Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No Division or Vital 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury death. M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3509 32. F gistrar's Signature

DHMH 17 Rev 1/2001

Registrar

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** Stines 2007 5:15 PM Angelina ΟŪ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Harbor Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 XF Director 01/01/1924 Maryland 216-16-6207 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28e-1 ehow other treumatic event, the Mudical Examinar must be notified at 1X Yes 2 □ No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 5 Items 23e United States ne filed within 72 hours after death all Hygiene. I other then "naturel", or Items 236 3320 Benson Avenue 21227 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: f Yes, Give Year or Dates: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Clerk Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H ie marked oth Be 2 Rosario Barranco Dominic Longo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an item 27 Rose Marie Longo Strouse-Daughter 6702 Hamerson Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Importent: If any injury or once. 07/11/2007 Baltimore, Maryland Cemetery 21. Signature of Funeral Service L 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Uremic Encephalopathy Physician /Medical Examiner Respiratory Failure
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Congestive Heart Failure MEDICAL EXAMINES Due to (or as a consequence of): CERTIFICATION APPROVED BY Box 68760 Myocardial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumonia autopsy performed? Yes 2 No Hip Fracture 1 ☐ Yes 2 ☐ No 1 Yes of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury Juftenth, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 Artatural 5 Pending investigation Fell while getting out of bed 1 ☐ Yes 2 ▼No July 4,2007 Unknown 2 Accident Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number of City or Town, State)
3320 Benson Ave., Balto., MD in by 4 Homicide St. Elizabeth Nursing Home Hospitel within 24 hours a To the Funerel I filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Vunelasmo; House Staff Physician RES 0001 July 04.2007 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover Street Baltimore, Maryland 21225 Veena Rao MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 2 2007 State AUG 0 2

DHMH 17 Rev 1/2001

Registrar

07-05934 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alexios Stavrakis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 0205 hrs August 3, 2007 **Medical Examiner** Alexios Stavrakis 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death N/A Baltimore City Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign 216-90-2523 Months Days Hours Director Dec 2,1963 Country) Md. 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location Baltimore Md. 1 Yes 2 X No Eastwood items 23a or 28a-f show ust be notified at once. death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6903 Eastern AVe. 21224 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 2 X No Greek Yes 2 X No specify: f Yes, Give Yea Specify Widowed Divorced 4 it: If item 27 is marked other than "natural", other tranmatic event, the Medical Examiner ď 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed permit. Pages 1 and 2 should be filed within 72 ho. Department of Health and Mental Hygiene. Important: If item 27 is marked an injury or other reconstruction. during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Adcor Industries Machinist 12 yrs. 2 yrs. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Konstantinos Be Stavrakis Maria Glykiadis 19a. Informant's Name/Relationship (Type, Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Demetrios Stavrakis 801 A Hillstead Dr. Lutherville Md. Date 7 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, oak Lawn Cem. 1 X Burial 2 Cremation 3 Removal from State Baltimore 2007 Donation 5 Other Specify: 22. Name and Address of Facility Connelly Funeral Home 7110 Sollers Point Rd nature of Furieral Service License Approximate Interval not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Part I. Enter the disease of complications that caused the death. Do Physician Between Onset and failure. List only one cause on each line /Medical Death a Narcotic and ethanol intoxication and cocaine use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED sician a tending physician use as the burial -^#53a,27,28a-f,perME,g870,8/22/07 TT Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 V No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes No After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural Pending 1 Yes 2 X No unk hours after death the Fnd 8/3/2007 lunk 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State determined 7006 Fait Ave Dundalk, MD (Specify) found at residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 within 2 To the 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 3, 2007 DOM of person who completed cause of death (Item 23a) 30. Name and addre Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. 31. Date filed (Month, Day, Year) strar's Signature State

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			1 - For State Registrar			-	ertifica				_	Reg. No	2007	25039	
	S Dharini		1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath Da	y Year	3. Time of Death	
	Physici /Medic		Elaine D. Stone								August			8:10A <sup>M</sup>	
	Examin	er	4a. Fecility Name (If not institution,			20			Location of	of Death			. County of Death		
	Funeral	2	8100 Connecticut  5. Social Security Number	3. Sex		(In yrs. last birtho	(ay) If Unde	vy Cl	If Under		8. Date of Bir	th	ontgomer 9. Birth	pplace (State or Foreign untry)	_
1	Director		577-16-1504	1 □ M <b>20X</b> F	3	36 Yrs	Months.	Days	Hours	Min.	(Month, Da Septembe	r 19	1920 Mai	yland	
	pur *		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town o	r Location							10d. Inside City Limits	
	Maryla 1 sho	ō	Maryland Montgo	merv		Chevy Ch								1 ☐ Yes 2 ☑ No	
	r 28s-	Director	10e. Street and Number	mery		onevy or		Code				10g. Ci	tizen of What Co	untry?	_
	238 o	al D	8100 Connecticu	t Avenue	#160	08	20	315				Unit	ted Stat	es	
	ems erm	ner	11. Marital Status	12. Was Dec	edent Ev	er in U.S.	13. Was Dece	dent of H	lispanic Ori an, Mexicar	igin? (Spe	cify Yes or No Rican, etc.)	D-	14. Race - Amei Black, White		
36	rs afte	by Funeral	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Gi Year or [	ive		1 🗆 Yes	2⊠ No	Specify:				Specify: Whi	te	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23s or 28s-f show wit, the Medical Ezember must be notified at	ed t	15. Decedent's	Education		16a. D	ecedent's Usu	al Occup	ation			16b. K	(ind of Business/l		-
215	thin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	-		) (G	live kind of wi fe. DO NDT i		during mos d)	of WORKII	ng				
7	filed wi Hygien sther th	Con		College (		H	omemak	er			/=	1	n Home		
gue	ntat H	Be	17. Father's Name (First, Middle, L								(First, Middle Imonds	, Maidei	n Sumame)		
<u> </u>	2 should be financial band Mental by and Mental by the marked of raumatic ever	ဥ	Emmett B. Daven			19b. M	lailing Addres	s (Street				er. City	or Town, State, Z	ip Code)	_
Σ S	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If I tem 27 Is marked other than "natural", or Items 23a or 28s-1 show or other traumatic event, the Medical Exertiret must be notified at		Frank G. Stoner		nd		-							MD 20815	
J.e.	as 1 a of Hea litem		20a. Method of Disposition 1 □ Burial 2 🏝 Cremation	3 MDamayal from	Ctata	20b. Place of D cemetery,	isposition (Na crematory or	me of other plac	(e) A	ugust	ate 4,	20c. L	ocation - City or	Town, State	
Ĕ	Page ment ant: It ury o		4 □ Donation 5 □ Other (Sp.			Montgomer	y Cremat	orium	1	-	007	Betl	nesda, M	aryland	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 ls any injury or other tra		21. Signature of Funeral Serve L	icente	MO								esda-Chevy MD 208	Chase, Inc. 14-3501	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that nly one cause on	caused tl each line	he death. Do not	enter the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
4.2	Physician		tmmediate Cause (Final disease or condition resulting in death)	a. Glion	na, r	nalignan	t							1 month	
	/Medical Examiner		resulting in death)	Due to	(or as a	consequence of)	:								
s#		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(urasa	eonsequence of)	67								_
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89 X	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Med	IF FEMALE:	23c. If yes, ou	utcome of	fpregnancy							23d. Date of deli	ven	,
P.O. Box	death a atter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1☐Live 4☐Preg	birth 2 nant at ti	Fetal death	3 ☐ Ectopic p 5 ☐ Other (s		1				Month	Day Year	
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S,	Se Co		Part II. Other significant condition	s contributing to d	death but	not resulting in th	ne underlying	cause giv	en in Part I	l.				the cause of death?	
ord	w require been si should b	eted	<del></del>											obably 4 Unknown	_
Vital Records,	hast pe2s	Completed									24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of	
	lcian: Th certificate ector, pag		25. Was case referred to medical	-					26 Place	o of Dooth	1 ☐ Yes	<b>2</b> √□ No	0 1 ☐ Yes	<b>3</b> √□ No	. –
	ysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient	t 2 ER/Outpa	atient 3 D	OA Oth	or				6 ☐ Other (Spec	cify)	
0	Attending Physician: The Isr death.  ector: After this certificate haby the funeral director, page	L :uo	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date (Mor	of fnjury oth, Day	Year) 28b. Tim	ne of	28c. Injur Wor	y at k?	1	28d. Describe	how infu	ıry occurred		
sio	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could no	ation			М		Yes 2		201 1	/C++			
Division of	l or At after of Direc	Certification;	4 Homicide determin	288. Plac	e of Infur ling, etc.	y - At home, farm (Specify)	, street, facto	y, office		1	City or To			iral Route Number,	
_	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	Medical C		Physician: To the tament and man		examination and/o									
	ro the	Mec	29b. Signature and title of certifier	and man	state		29	c. Licens	e number			29d. Da	ate signed (Monti	h, Day, Year)	
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â	1		30. Name and address of person w	n completed cau	ise of dea	ath (Item 23a) (Ty	pe, Print)								
	10		Ralph Boccia, M				Drive,	_Sui	te 41	00,	Betheso	la, 1	Maryland	20817	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 6	2007	egiştrar	's Signature	Break?	0							
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DHMH 17 Rev 1/2001

SAID TO BE: LARA SNYDER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 **Physician** 07:05 AM JAE SNYDER 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OWINGS MILLS BALTI MORE 12613 WATER SPOUT COURT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/28/1982 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F Days Hours Min. md 213-02-2759 25 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number USA 21117 12613 WATERSPOUT COURT Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify. Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meones. Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCHLOSS SNYDER MARY JANE SAMUEL 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 12613 WATERSPOUT COURT, OWINGS MILLS, MD 21117 MARY JANE SNYDER / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State BALTIMORE HEBREW REISTERSTOWN, MD 08/03/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CYSTIC FIBROSIS 25 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an page 2 performa director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No nours after death.

neral Director: # 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 🛙 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Misan & ML 200/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 1830 E. MONVMENT ST BALTIMORE BoyLE M.D MICHAEL 31. Date filed (Month, Day, Year) AUG 0 6 32 Registrar's Signature State 2007 Registrar

The law requires that the death certificate be executed physician and s the burial-tran attending pl for use as t tal or Attending Physician: after death.

Director: / ral I

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Department of Health Important: If item 27 any injury or other to once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

within 24 hou	Completely fi	Medical
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Completed Be ျှ Examine Physician/Medical þ Completed Be Certification: To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) no mariner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 4,2007 046187 P. KURUNCEA, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ; 11125 ROCKVILLE PIKE, #208, ROCKVILLE, MD 2085 KURUVICA 410 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Michael Paul Toney 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last)
Michael Paul 2. Date of Death 3. Time of Death Physician/ Toney Year 1302 hrs August 1, 2007 **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 6400 Blk. Holabird Ave Baltimore 9. Birthplace (State or If Under 24Hrs. Date of Birth (MM/DD/YYYY) If Under 1 Year 5, Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Days 240-57-6334 Months Hours Min Director 33 March 19,1974 Country) NC 1 **XM** 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Yes 2 X No ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. NC Rutherford Rutherfordton 10f. Zip Code 10g. Citizen of What Country? Direct 10e. Street and Number 361 Weeks Road 28139 USA Funeral 14. Race - American Indian, Black 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces' 1 X Never Married 2 Married Yes 2 X No White iltimore, MD 21215-0036

iii. Pages I and 2 should be filed within 72 hours after d
retnen of Health and Mental Hygiene
retnent: If item 27 is marked other than "natural", or
y or other traumatic event the Market. Divorced , Give Year Yes 2X No specify. Specify Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Construction Class Lineman 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Gilda Stiles Jackie Edward Toney Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28043 Jackie Edward Toney / Father 153 Morningstar Lake Road, Forest City, NC 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, Itimore, 20a. Method of Disposition crematory or other place)
Sulphur Springs
Baptist Cemetery definent of a portant: If Burial 2 Cremation 3 Removal from State August 7,2007 Forest City, NC Donation 5 Other Specify Name and Address of Facility
Charles L. Stevens Funeral Home Inc
1501 East Fort Avenue, Baltimore, M 21, Signature of Funeral Service Licenses \* 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Electrocution Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed ian/Medical X AMENDED perFH,g870, 8/23/07 TT attending physician or use as the burial -UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available been prior to completion of cause of autopsy certificate has performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be examiner? Other<sub>4</sub> Hospital:, DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 Yes ို No 28a. Date of Injury (Month, Day Year) Aug 1, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject electrocuted at work Certification 1250 hrs 1 Natural 1 ✔ Yes 2 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 6400 Blk. Holabird Ave, Baltimore, MD determined (Specify) On truck the Hospital To the Funeral 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 1 and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie August 2, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) i 0 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day **Physician** Month 6:30 AM 31, Whitted 2007 Leroy JU14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4409 Rockville Montgomery Ives Street If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 12 M 2□F 55 Director 220-60-4545 August 20, 1951 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Director Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 20853 4409 Street USA IVES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after comparament of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or having or other framment. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Parks and Recreation Maintenance 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stockett Ernestine Whitted, St. Duane ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Ives Street Duane Whitted Sr. Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 31, 2007 Anatomy Gifts Registry Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Suite P. 21076 Hanover, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** patic Carcendma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly 3 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗡 No Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14 ~0 055258 August 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 200 012 Road Colympia, mo (olumbia

Registrar DHMH 17 Rev 1/2001

State

B.

31. Date filed (Month, Day, Year)

WIKS

0 6

2007

32 Registrar's Signature

			For State Registrar	State of Ma		/ Depa		f Health	and M	lental Hygi	iene	07	250	
			Decedent's Name (First, Middle,	Last)		•	-			2. Date of Deat			3. Time of [	Death
	Physici		Pau1	М.	Wilhe:	Lm				Month August	3, 20	007	11:20	A <sup>M</sup>
	/Medic		4a. Facility Name (If not institution,	give street and number)			4b. City, Tow	m, or Location	of Death			y of Death		
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	Funeral			3. Sex 7. Ag	ge (In yrs. la:	st birthday)	If Under 1 Y			8. Date of Birth	Voor)	9. Birth	place (State or	Foreign
м	Director		220-32-2804	1⊠M 2□F 7	1	Yrs.	Months Da	ays Hours	Min.	Feb. 5,	1936	M	place (State or ntry) aryland	1
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	how		10a. State 10b. County		10c. City,	Town or Lo			-				10d. Inside City 1 ☐ Yes	
	a Ma a-1s	cto	MD Ba	ltimore			Keis	terstov	WII					22,110
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show ta Modeal Ext. viller it ust be notified at	Director	10e. Street and Number				10f. Zip Co			11	og. Citizen of	What Cou	ntry?	
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	ams err	Inel	11. Marital Status	12. Was Decedent Armed Forces?	?	. 13.	Was Decedent If Yes, specify	of Hispanic Or Cuban, Mexica	rigin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)		ice - Amen ack, White,	can Indian, , etc.	
36	or It	by Funeral	1 Never Married 2 Marrie	If Yes, Give	No		1 ☐ Yes 2 <b>反</b>	No Specify	<i>'</i> :		Spec	ify: LT	hite	
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	filed withi Hygiene. othar than ent, IDE M		17. Father's Name (First, Middle, L	ast)		114211			er's Nam	e (First, Middle, M			<u> </u>	
an	Mental Mental arked o	o Be	Millard	Wi	llhelm				Milo	dred	Haze1	Но	11oway	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If it itam 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic event. It is Mystlest Ext. other traumatic event. It is Mystlest Ext. other traumatic	2	19a. Informant's Name/Relationsh	p (Type, Print)		19b. Maili	ng Address (St	reet and Numb	oer or Rur	al Route Number	City or Tow	n, State, Zi	p Code)	
<b>≥</b>	d 2 sho th and traums		Paul M. Wilhelm,				Wengate			ngs Mill		2111	_	
စ်	Health Health tam 27 othar tr		20a. Method of Disposition		20b. Pla		osition (Name o			Date	20c. Location	- City or T	own, State	
DO	ages ant of t: If i		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		1		n Mem.		8/6/	07	inksb	urg,	Marylar	nd
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.		21. Signature of Funeral Service L				2. Name and A			11824				
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760,	Physician /Medical Examiner  e parial-Itausit	cal Examiner	dise, se or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ue to (or as b. Due to (or as d	s a conseque		al i	Cont	- P	Ano			23 m	mith
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Vital	fing Physician: n. After this certific funeral director,	Be	25. Was case referred to dical examiner?	Hear hali				Othor		th Check only	(e)	-	MX	2
of\	Physic this c	2	1 ☐ Yes 2 ☐ V6		ient 2 E				lursing H	ome 5 Reside		ther (Spec	ify)	0
		Certification;	27. Manner of Death 1 Natural 5 Pending		ay Year)	28b. Time o Injury		Injury at Work?	- الم	28d. Describe h	ow injury occ	urred	HOO	HE
Sio	Attanding r death. sctor: Afte	catl	Accident investig 3 ☐ Suicide 6 ☐ Could n	at ha			М	1 Yes 2		28f. Location (S	troops and Miss	-hos os Du	ral Pauto Alum	hor
Division	fter d irect n by	Ħ	4 Homicide determine	286. Place of Ir	njury - At hor etc. <i>(Specify)</i>	ne, tarm, st	reet, factory, o	ffice		City or Tow		nder or mu	IZI HOULE IVUITI	Der,
Ω	To the Hospital or Attanc within 24 hours after death To the Funeral Director; completely filled in by the	edical Ce	29a. Certifier 1 Certifyin (Check only 2 Medical )	Physician: To the bes	t of my know	rledge, dea	th occurred at the	he time, date a	and place	, and due to the c	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s	s)
	tha F tha F tha F	ledi	one)	and manner s	stated.			icense numbei			9d Date ng			
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225	5		30. Name and address of person	5555Sou	th (	ate	, Print) 754a	ot W	651	niuster	MD	2113	57	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	5 2007 2007	trar's Signat	ure J	Small J	······································						

DHMH 17 Rev 1/2001

ORIGINAL

07-05758 Abimbola Aladejana Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 25045

		For State		Cer	Certificate of Death					Reg. No.  2 Date of Death 3. Time of Death				
Physician/ Examine	1. r	Decedent's Name (First, Middl Abimbola		Aladejana						Date of Dea Month July 26, 2	Day 2007	Year		3. Time of Death 2225 hrs
	4a	. Facility Name (if not institution  Doctors Community H		imber)		lb. City, Tow Lanham		ation of	Death			c. County o Prince G		's
Funeral Director	5.	Social Security Number 214-31-0277	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs			If Under Hours	24Hrs. Min:	8. Date of B				hplace (State or Mashington untry) DC
	10 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	De. Street and Number  7023 Woodthrus  1. Marital Status  X Never Married 2 No.  3 Widowed 4 Di  15. Decedent's Education (Special Property of Secondary (0-12)  12th  7. Father's Name (First, Middle Solomon Alade	te Georges  Sh Dr.  12. Was De Armed F 1 Yes vorced If Yes, Give Ye or Dates: ecify only highest gra  College ( e, Last) e jana	Las	16a. Deceder during m	10f. Zip Co 207 as Decedent res, specify ( Yes 2 X nt's Usual Octoors of working one	of Hispan Cuban, M No s coupation ng life. Di	texican, in the specify:  In (Give kind on NOT to some steel)  Mother's Steel  and Number steel	nd of wo	ork done ed)  (First, Middle Ad	16b 1 e, Maide eye1	White Specify: . Kind of Bunone Surname mi	- America, etc. Blassiness/I	can Indian, Black, a C k
Baltimore permit. Pages I Department of Important: If injury or other	2	9a. Informant's Name/Relation Solomon Alac  20a. Method of Disposition  1	on 3 Removal Specify: te Licensee	from State M	Place of Dispo crematory or o it. Oliv	Woodtl sition (Name ther place) ret Cer Name and A	hrus e of ceme mete ddress o	h Dr etery, ry f Facility er R	8/3, J.I	Date /2007 B. Jen Lando	i, M	D 20 c. Location Washin s Fun , MD	706 -City or ngt c eral 207	Town, State on, DC Home 785 Approximate Interval
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. Box 68760, the death certificate be executly the attending physician and check for use as the burial - transcribed for use as the burial	by Physician/Medical	IF FEMALE: 3b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 L  Part II. Other significant cond	23c. If ye 1 Live 4 Pre	27, perME, C s, outcome of pre e birth gnant at time of a known g to death but not	egnancy 2	Fetal death Other (Spec	3		c pregna	23e. D			tribute t	Day Year of the cause of death?
Physi	Completed	2 Accident In 3 Suicide 6 C 4 Homicide	Hospital: 1  28a. Di (Mc ending ivestigation could not be etermined  3 Physician: To the Examiner: On the bas and manni	26.Place of Death (Check  26.Place of Death (Check  27. Inpatient 2 FR/Outpatient 3 DOA Other 1 Nursing  a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  8e. Place of Injury - At home, farm, street, factory, office building, etc.  Specify)  at the best of my knowledge, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred in the interpretation of the property of the basis of examination and/or investigation, in my opinion, death occurred in the property of					24a. Was an autopsy performed?  1  Yes 2 No 1  ack only one)  28d. Describe how injury occurre  28f. Location (Street and Numbe or Town, State)  and due to the cause(s) and manner red at the time, date and place, and did			oth other or land of due to	Yes 2 No ner:  Rural Route Number, City tated.	
Downa Mincarch, M.D.  30. Name and address of person who completed ca						11 Penn	O.C.N		nore, N	 ИD 21201		July 27, 2	2007	
	ate		ear) a 32	. Registrar's Sign					_,					

ORIGINAL

OCME

07-05721 Charles Acree, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 25046

		-	- For State		Certific	cate of	Death_					. No.				
-	Physicia		. Decedent's Name (First, Midd	lle,Last)						2.	. Date of Death Month	Day	Year	3.	Time of Deat	h
	l Examir		Charles Thom	as Acree.	Jr						July 26, 20	07			0705 hrs	
		4	la. Facility Name (if not instituti	on, give street and nur	nber)	41	b. City, Town	, or Lo	cation of I	Death			ounty of	Death		
			Carroll Hospital Cent	er		1	Westmin	ster				Car				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	irthday)	If Under 1 \	Year	If Under 2	24Hrs.	8. Date of Birth	(MM/DD	/YYYY)	g. Birthp	lace (State or	
	Director		220-04-0837	1 X M 2 F	39	Yrs.	Months [	Days	Hours	Min.	April'	15 1	968	Foreign Coun	try) MD	
				IAM Z F		115.					-1					
pr. pr. 19.19		eva.a	Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Tow	n or Location	on							1	0d. Inside City	y Limits
	w any			roll		neyto									1 XYes 2	No
ن	land f sho	ġ.		TOTT	10	uley co		10			110	g. Citizer	n of Wha	t Countr	v?	
ال	h the Maryland 3a or 28a-f sho otified at once.	Director	10e. Street and Number				10f. Zip Cod	ЭС				g. Oluzei	TOI TTIE	i ooana	, .	
	the la or		10 Church Stre	et			2	2178	37				JSA_			
_	with ns 22 be no		11. Marital Status	12. Was Dec	edent Ever in U.S.	13. Was	s Decedent of es, specify Cu	f Hispa	anic Origin Mexican F	n? (Spe Puerto F	cify Yes or No-	14	Race - White,		an Indian, Blac	ck,
	leath r iter	Ĭ.	1 Never Married 2 X	Married Armed Fo	2X No										White	
	after death with the Maryland "al", or items 23a or 28a-f she iner must be notified at once		3 Widowed 4 D	ivorced If Yes, Give Yea			Yes 2 🔀						oecify:			
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	5-0036 lled within 72 Hygiene. tother than the Medical	하	17. Father's Name (First, Middl	ie, Last)				18	Mother's	Name (	First, Middle, N	Maiden St	urname)			
	e file		Charles T. Ac	ree. Sr					Mar	Lene	Mulhea	arn				
	2121 ould be fil   Mental     marked   ceent,	To Be	Charles T. Ac	nship (Type, Print )		19b. Mailing	g Address (S	Street a	and Numb	er or R	ural Route Nun	ber, City	or Town	, State,	Zip Code)	
	MD 21215-0036 at 2 should be filed within 72 hours that and Mental Hygiene. in 27 is marked other than "natur aumatic event, the Medical Exam		Jennifer Acres	-/wife		1931	Trevar	nio	n Roa	ad T	aneytov	vn, N		2178	7	
	ore, MD 21215-003 se I and 2 should be filed withi of Health and Mental Hygiene. If item 27 is marked other th	ŀ	20a. Method of Disposition			e of Dispos	sition (Name o				Date	20c. Lo	cation -	City or T	own, State	
	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after dealt ment of Health and Mental Hygiene.  Itant: If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examiner must or other traumatic event, the Medical Examiner must	ļ	1 XBurial 2 Cremati	on 3 Removal fr	om State	natory or ot		4 - 3	D - 1		30/2007		1 0	17	e, MD	
	Famen tant	. I	4 Donation 5 Other	Specify:	Lake		Memor:				o and (				e, MD	
1	Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tri		21. Signature of Funeral Servi	se mensee		223			erar	DO	ne and ( d West	mine	stor	MT)	21157	
			23a. Part I. Enter the disease,	or complications that (	aused the death. Do	not enter t	he mode of d	vina. s	uch as ca	rdiac or	respiratory arr	est, shoc	k, or hea	art	Approximate	
	hysician ≀Medical		failure. List only one cau	co on each line											Between Or Deat	
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		اير	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):											
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	687 ertific ding	an/	23b. Was decedent pregnant in past 12 months?	LIVE	birth nant at time of death		etal death		Ectopic	pregna	incy		Month	_	)ay `	real
	Box 68's death certiff	sici	1 Yes 2 No 9	Unknown 9 Unkr		5 0	ther (Specify	<i>'</i> ) _								
	he de y the	Physician	Part II. Other significant con			ulting in the	underlying ca	ause gi	iven in Pa	ırt I.	23e. Did	tobacco u	use contr	ibute to	the cause of d	leath?
	Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rate death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	by I	Fait ii. Other significant con	iditions contributing	to doda barner			Ů			1 Y	es 2	No 3	Prot	oably 4 🗸 U	Inknown
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	eco he law tte has ige 2 s	Completed										2 N		✓ Ye	es 2	No
	tal Recian: The certificate ector, page		25. Was case referred to med	dical			26	.Place	of Death	(Check	only one)					
	Vital Rec ysician: The l his certificate l director, page	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸 E	R/Outpatier	nt 3 DO.	A	Other <sub>4</sub>	Nursir	ng Home 5	Reside	nce 6	Othe	r:	13.
	of V ing Phy After th	⊢	27. Manner of Death	28a. Dat		8b. Time of	f Injury 28	c. Injur	ry at Worl	(?	28d. Describe	e how inju	iry occur	red		
	nding II. F. Af	io E	1 National		th, Day, Year)	Fnd 6:	23 am	1 Y	res 2 X	No	unk					
	SiO Atter	cat		28e Pla	7/26/2007   ace of Injury - At hom			office b	uilding, e	tc.	28f. Location	(Street a	nd Numb	er or Ru	ural Route Nur	mber, City
	Divi	Certification:	U. =	Joula not be	Found mult						85° Carr	OLL V	iew A	ve. V	Vestmins	ter, MD
	ospita hour inera		4 Homicide  29a. Certifier 1 Certifyin	g Physician: To the b						ace, and	d due to the ca	use(s) an	nd manne	er as stat	ted.	
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death within Enter death completely filled in by the funeral director, page 2 should be detached for use as	ica	(Check only one) 2 Medical	Examiner: On the basis	s of examination and	d/or investig	ation, in my o	pinion	, death o	ccurred	at the time, dat	e and pla	ace, and	due to th	ne cause(s)	
	To t To t	Medical	29b. Signature and title of ce	and manner	stated.				e number						onth, Day, Year	r)
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	WJZ		Cell of H	tella	0											<del></del> -
	0		30. Name and address of per			ຜa) I 11 Denn	Street, B	altim	ore MI	2120	01					
				Assistant Medica	100		. Outet, D	anul II	J. J. 1VIL							
		itate	<ol> <li>31. Date filed (Month, Day, Ye</li> </ol>	ear) 32.	gistrar's Signatur		and a									

ORIGINAL

			1 - For State Registrar	State of I	Marylan				ealth a Death	ind Me	ental Hy	giene Reg. No		The same of	25047
	Physici	an	Decedent's Name (First, Middle, Las     FRANK ABRAMS	t)							2. Date of De Month July 21	Da	у 7	Year	3. Time of Death 5:25 AM
	/Medic Examir		4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location of				. County o	of Death	- 123
×.			Carriage Hill Nursing	Home			Bet	hesda				M	ontgo	nery	
Ú.	Funeral Director	48.	5. Social Security Number 6. S 183-32-0728	9x 7. ØM 2□F	Age (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	B. Date of Bi (Month, Di ept. 15	ay, Year)		Cour	place (State or Foreign htry) ylvania
	D		Usual Residence of Decedent									,			
	arylar show dat	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits 1 ☐ Yes 2 ② No
	Ba-f	Director	Maryland Montgomery	·	Beth	esda	1								
	with t		10e. Street and Number				10t. Zij	Code	,				tizen of W		ntry ?
	eath me 23	erai	4978 Sentinel Drive, #	12. Was Decede	nt Ever in U	S 13 V	Was Dece	2081		nin? (Spec	ify Yes or N		ted St		can Indian,
336	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturet", or iteme 23e or 28e-f show event, the Mad cal Exemitive could be cutified at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force  1 🕅 Yes 2  If Yes, Give  Year or Date	s? □ No		f Yes, spe 1 🗆 Yes	cify Cuba	n, Mexican Specify:	, Puerto R	ican, etc.)			, White,	etc.
9	2 hou	ted	15. Decedent's Ed	ucation		16a. Deced	dent's Usu	al Occupa	ation	af warden		16b. K	and of Bus	siness/In	dustry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest gra	College (1-4	or 5+)	life. I	DO NOT u	ise retired	luring most )	or working	g				
121	Hygier Hygier Sther th		17. Father's Name (First, Middle, Last)	5+		Docto	or		10 Mathe	da Nama	/Circle Adjustedle		dical	-1	
lanc	d be fi	To Be	Hyman Abram	19					Dora		(First, Middle Ber		i Surriame	*)	
Maryland	2 should be filed v and Mental Hygie Is marked other t raumatic event, III	-	19a. Informant's Name/Relationship (			19b. Mailir	ng Addres	s (Street a			Route Numb		or Town, S	State, Zip	Code)
	0 = 0 =		Shirley D. Abrams, wi	.fe		Place of Dispo	sition (Na	me of	1-07	)5 Be	thesda,		1and ocation - (	208 <b>1</b> 6	
E E	Pages nent of h ant: If Its ary or of		1 ☑ Burial 2 ☑ Cremation 3 ☑ 4 ☐ Donation \$ ☐ Other (Soecify		He	semetery, cren s Israel	•			7/23/2	2007	Washi	ngton	, DC	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signat ve of Furieral Service Ligar	See /hu	*	22	. Name a	nd Addres	s of Facility	Hines	-Rinald ue, Sil	i Fun	eral F	lome,	Inc. 20904
	·# *		23a. Part1. Enter the disease, or compshock, or heart failure List only	olications that cau	sed the deat h line.	h. Do not ent	er the mod	de of dying	g, such as	cardiac or	respiratory a	irrest,			Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		RT FAILU	JRE								Onsot and Doam
- <del>100</del> 100	Examiner			AORTIC	as a conseq STENOSI										
	₽ #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):									
	be executed sicien and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. ATRIAL	FIBRILL as a conseq			_							
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9	tificate I ng physi as the t	Medic	15.55.11.5	. 0.											
O. Box	It the death certificate be executed by the attending physicien and teched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 Feta t at time of d	I death 3	Ectopic p Other (s)						23d. Date Mon		ery Day Year
s, P	es that it gned by be detec		Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did	tobacco	use contri	bute to t	he cause of death?
ords	w require been sig should b	edt	CHRONIC RENAL FAILURE								1 🗆	Yes 2	□No	3 🗌 Prob	pably 4 🕅 Unknown
Record	has has	Completed by	27								24a. Wa: auto perf 1 \( \text{Yes}		di	fere auto nor to co eath?	ppsy findings available mpletion of cause of
Vital	icien; Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑ No			ER/Outpatien	t 3 🗆 🗅	OA Othe	er: 4 🛭 Nui	rsing Hom	e 5 🗆 Res	idence	6 □Othe	r (Specif	(y)
	ing After une	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of l (Month,	njury Day Year)	28b. Time of Injury	м	28c. Injury Work 1 [] `	rat k? Yes 2 □ N		8d. Describe	how inju	ry occurre	bd	
Division	- 0 b-	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At he etc. (Specif	ome, farm, str	eet, factor	y, office		21	8f. Location City or To	(Street allown, State	nd Numbe e)	or Aura	al Route Number,
	he Hospital or n 24 hours aft he Funerel Di pletely filled in	edical (	29a. Certifier 1 Certifying Ph	ysician: To the be liner: On the basi and manner	s of examina	owledge, death	occurred vestigation	at the tim	ne, date and pinion, deat	d place, ar	nd due to the d at the time	cause(s date an	and mar d place, a	ner as s	tated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	/) -	-1019G.		29	c. License	number			29d. Da	ite signed	(Month,	Day, Year)
	9		> Lash	of no	)			D313	L9			Ju1	y 21,	2007	
			30. Name and address of person who				,							art of Madeinson	
			Loreto Albiol, M.D., 8					2000	a, MD	20814					
	Sta Registi		31. Date filed (Month, Day, Year)	32.69	istrar's Signa	S A	ast.								

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Della Blanche Bosley 4:50 a<sup>M</sup> July 26 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Westernport, Moran Manor Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 12 1918 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2**X** F 212-24-1352 88 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location rel', or iteme 23a or 28e-f show Exercises must be notified at MD. Allegany Barton 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23526 Middle 21521 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2/CXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: δ 3€Widowed 4 ☐ Divorced "naturel", in then "nature the Medical E Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Housework Elementary/Secondary (0-12) College (1-4or 5+) Homemaker unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit timent of Health and Mental H tant: If item 27 is marked ott jury or other treumatic even Walter Miller Katie Preston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 ie
eny injury or other treu Carolyn Duncan/ daughter 7322 Potter Road, Flushing, Michigan 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Laurel Hill Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Barton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Boal Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronan /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certilicate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstrution 1 Yes 2 No 3 Probably 4 Whiknown been si 24b. Were autopsy findings available prior to completion of cause of death? perterision autopsy performed 2∏ No 1 Yes 2 2 100 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this Atter thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation death. 1 | Yes 2 | No within 24 hours after death To the Funerel Director: / completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7/26/09 121244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 26 2007 Registrar

-05484		Please Type or Print in Bla State of Maryland /	ack Ind	elible In	k. Ens	and Mental	Dies Ar L'Hygien	e regini	e.	
hn Michael Bir		for State of Maryland /	Depan Certi	ficate of	Death	and Menta	rriygion	Reg. No	. 91	107 2501.
	R	edistrar . Decedent's Name (First, Middle,Last)		noato o			2. Date	e of Death	j. va	3. Time of Death
Physicia edical Examii	_						July	nth Day 17, 2007	Tear	0745 hrs
		John Michael Birchfield  a. Facility Name (if not institution, give street and number)		4		vn, or Location of E	Death	- '	4c. County of De Garrett	eath
		756 Meyersdale Road			Grantsv		10.0	ate of Birth(MI		Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. las		If Under	1 Year If Under 2 Days Hours	Min		Fo	reign CountryArkansas
Director	1	432-53-7674 1XM 2F		36 Yrs.			Apı	ril 13,	, 19/1	COUNTY AL KAIIDAD
202. 22 Tax - 22-11		Jsual Residence of Decedent  10a. State 10b. County	10c. City. T	own or Locati	on					10d. Inside City Limits
ınd show any nce.	-			tsville						1 Yes 2 X No
faryland 28a-f sh	흲	MD Garrett  10e. Street and Number	GLair	CSVIII	10f. Zip C	ode		10g. C	Citizen of What C	Country?
e Mai or 28	ire	756 Meyersdale Rd.			2153	36		ט	SA	
with the s 23a e noti	Funeral Director	11. Marital Status 12. Was Decedent		3. 13. Wa	s Decedent	of Hispanic Origin Cuban, Mexican, F	? ( Specify )	res or No-	14. Race - A White, et	merican Indian, Black,
seath r	al l	1 Never Married 2 X Married Armed Forces? 1 Yes 2	X No					,,	Casaifu	w/
after o	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1.1.15	1		No specify:	nd of work do	one 16	Specify: b. Kind of Busin	White ess/Industry
hours after		15. Decedent's Education (Specify only highest grade con		during m	nost of worki	ing life. DO NOT us	se retired)			
36 in 72 han "	ompleted	Elementary/Secondary (0-12) College (1-4 or 12		Labor	er				Labor _	
5-0036 led within 72 Hygiene. other than '	S	17. Father's Name (First, Middle, Last)							ien Surname)	
21215-0036 nuld be filed within 7 Montal Hygiene. marked other than	æ	Ronnie Birchfield					Coll		City or Town	State Zin Code)
D 21215-0036 should be filed within 72 hours after death with the Maryland and Montal Hygener 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be natified at once	٥	19a. Informant's Name/Relationship (Type, Print )				(Street and Numb				21536
imore, MD 2121. Pages I and 2 should be fi nent of Health and Montal I lant: If iten 27 is marked or other traumatic eyent.		Kimberly J. Birchfield/Wif	e 20b. F			e of cemetery,	Date	e 2		ity or Town, State
ore, slar of Hez If itel		<ul> <li>20a. Method of Disposition</li> <li>1 X Burial</li> <li>2 Cremation</li> <li>3 Removal from S</li> </ul>	tate C	rematory or o	ther place)		71177 2	1 200	7 Crant	sville, MD
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and W Important: If item 27 is m injury or other traumatic.		4 Donation 5 Other Specify:	Me			Address of Facility				
Balt Sermit Depart Impor		21. Signature of Funeral Service Licensee		P	.O. Bo	ox 257, C	Grants	ville,	MD 21	536
Physician	$\vdash$	23a Part I. Føter the disease, or complications that cause	d the death.	. Do not enter	the mode o	f dying, such as ca	rdiac or resp	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
/ / / dical	1. 7	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertens								Death
xaminer		or condition resulting in death)  Due to (or as a cons	sequence o	f):						
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Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be executed cours after death. After this certificate be been signed by the attending physician and cours in the channel of the control of the control of the control of the course of the course.	calE	X UNPENDED AMENDED 7		070 0/	. /O7 rm					
O, e be e ysician burial	<u>ğ</u>	X UNPENDED AMENDED, 7,1  IF FEMALE: 23c. If yes, outc	perME,g	8/0, 8//	707 11				23d. Date of d	
876 tificat ing ph	sician/Medi	23b. Was decedent pregnant in the		2	Fetal death	3 Ectopic	c pregnancy		Month	Day Year
ox 6 ath cer attendi	sicis	1 Yes 2 No 9 Unknown 9 Unknown	at time of de	eath 5	Other (Spe	cify)			1	
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P.O.	<u>a</u>							1 Yes		Probably 4 V Unknown
ds, equire	Completed							24a. Was ar autopsy		ere autopsy findings available for to completion of cause of
COL law r has b	du							perform		eath?  Yes 2 No
Re : The iffcate	ြိ	25. Was case referred to medical				26.Place of Death	(Check only			
/ital	o Be	examiner? Hospital: 1 Inpa	atient 2	ER/Outpation	ent 3 🔲 [	DOA Other	Nursing H		tesidence 6	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the raster cleath.  The state of the record of the rectificate has been signed by the state of the state	٦	27 Manner of Death 28a, Date of I	Injury ny,Year)	28b. Time	of Injury	28c. Injury at Worl	- 1	d. Describe ho	ow injury occurre	ed
On lendin eath.	] i	1 X Natural 5 Pending 2 Accident Investigation				1 Yes 2		f Leastian (St	reet and Number	er or Rural Route Number, City
ViSi or Att filter de Direct		3 Suicide 6 Could not be 28e. Place of	f Injury - At	home, farm, s	treet, factor	y, office building, e	etc.   281	or Town, Sta		, 0, 10, 10, 10, 10, 10, 10, 10, 10, 10,
Division  Hospital or Attend 24 hours after death. Funeral Director:	Certification:	4 Homicide determined (Specify)		des desth of	sourred at th	ne time, date and n	lace and du	e to the cause	e(s) and manner	as stated.
5 4 5			examination	and/or invest	igation, in m	ny opinion, death o	ccurred at th	e time, date a	ind place, and d	ue to the cause(s)
To the vithin 2	Medical	and manner state 29b. Signature and title of gertifier	ed			9c. License numbe			29d. Date sign	ed (Month, Day, Year)
	"	( Chale-net				O.C.M.E.			July 18, 20	07
		30. Name and address of person who completed cause	of death (Ite	em 23a)						
		Laron Locke MD. Assistant Medical E	Examine	111 Pe	enn Stree	et, Baltimore, N	MD 21201			
	Stat	9 6 2007	strar's Signa	ature	No.					
Reg	istra	TOL & G LOUI	Sant D	r Allend	10/19 /1					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2310 2007 Taini /Medical cility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Deat Examiner Age (In yrs. last birthday) Birthplace (State or Foreign Chuntry) **Funeral** 1 🗌 M Director land with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2167 Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Yes, Give ear or Dates: ۵ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work doubeduring most of working life. DO NOT use retired) if Health and Mental Hygiene. condary (0-12) College (1-4or 5+) Be ၉ 19b. Mailing Address (Street and /daughter 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Furieral Service Licenses 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years Physician ArtaroSclovotic Cardio Vascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): The law requires that the death certificate be executed Exami ed by the attending physician and detached for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3₹ Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Other: 1 ☐ Yes 20 No Medical Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Shoulderd

Registrar

State

31. Date filed (Monti

BAG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8870 8-16-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Veronica **Braniecki** J. 2. Date of Death **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbur If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) 10/15/1943 cial Security Number Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🛣 F Hours 204-32-9939 63 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Wicomico 1 ☐ Yes 2 No Maryland Parsonsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31630 Hideaway Drive 21849 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 procurment assistant hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill I Health and Mental H tem 27 is marked oth Be Robert Breidenbach Veronica Core 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Braniecki/husband 31630 Hideaway Dr., Parsonsburg, MD 21849 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or 7/20/07 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HOILOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 URKel CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMYOTROPHIC SCLEROSIS **Physician** LATBRAL /Medicai Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to for as a consequence of Examiner that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 No certificate Division or Vital 1 Yes 2 No 1 Ves funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 ☐ Yes 1 Inpatient 2 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier (Check only one) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07/12/07 D0058410 vu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPICA POBOX 1733 SALISBARY MG. 21801 COASTAL CHULAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** LINDA BUNTING 0 20 /Medical 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL Winnerd REGIONAL MLISBURI ENINSULA ENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Months Days Hours 56 22, Director 216-54-9148 FEB. 1951 MÁRYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37494 OLD FARM ROAD 19975 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ATWOOD D. BRADFORD ဂ္ HELEN SHOCKLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED C. BUNTING III/HUSBAND BOX 451, SELBYVILLE, DELAWARE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dopation = 5 □ Other (Specify) ROXANA CEMETERY 7/25/07 ROXANA, DELAWARE Signature 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Parti. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Jeans disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or frijing Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea:
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a d be detached for 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Thpatient P 2 ER/Outpatient 3 DOA 27. Ma ur r of Death 28h. Time of 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide within 24 hours a

To the Funeral I Hospitai hours 🗹 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JUL 2 4 2007

Ether TON

30. Name and addres

31. Date filed (Month, Day, Year)

100 E. CARROLL St. SAlisbury Md. 21801 32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

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July 21, 2007

State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of Health and I Certificate of Death		giene Reg. No. 🤈 🗋 🗍 🧻	25053
×_	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Year	3. Time of Death
	/Medic	al	Clara Blount  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	DULY	4c. County of De	7 2047 W
	Examin	er	DORCHESTER GENERAL HOSPITAL CAMBRIDGE		DORCHE	STER
(t)	Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	y, Year)	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent	03-06	-1923   N	. C
	Maryland -f show fied at	tor	10a. State 10b. County 10c. City, Town or Location  Md. Dorchester Hurlock			10d. Inside City Limits 1 ☐ Yes 2 No
	th the or 28a e noth	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
	s 23a nust b		4807 Skeet Club Road 21643  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	'nasify Van as Na	USA 14. Race - Am	erican Indian
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	Armed Forces? If Yes, spedfy Cuban, Mexican, Puèri	to Rican, etc.)	Specify:	ite, etc.
5-0036	2 hour latural			adeim a	16b. Kind of Busines	lack s/Industry
	be filed within 72 ho ital Hygiene. d other than "natur event, the Medi-al.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work forms and the properties of the propertie	rking		
22	e filed w al Hygiel other th	S	6 Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle,	Pickle F Maiden Surname)	actory
Maryland 2121		To Be	Henry Leigh Alvina		,	
ary	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Re	ural Route Numb	er, City or Town, State,	Zip Code)
_	s 1 and f Health item 27 other tr		Alvina Cox / Daughter P.O.Box 455, Lewis  20a. Method of Disposition   20b. Place of Disposition (Name of	ton, N. (	20c. Location - City of	r Town State
nor	<b>e =</b> 13		1 Magazia 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)			
Baltimore,	permit. Pa Departmer Important: any Injury once,		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Be	1/-0/  nnie Si	Federals	burg, Ma.
ň	an)		516 S.Main St.	,Hurlo	ck,Md.216	43
			23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	1	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Miconvilled Typical	M		The.
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Acute Microschi Typircli  Due to (or as a consequence of):  The control of the control o			10400
- 45	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
_	xecute and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C			
09/89	tificate be executed g physician and as the burial-transit		d			
	± 0 66	Medical	IF FEMALE.			
Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	elivery Day Year
<u>.</u>	the dea the a	ysic	1 Yes 2 The 9 Unknown 9 Unknown 9 Unknown			<b></b> ,
<u> </u>	w requires that the debeen signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	obacco use contribute	to the cause of death?
Sign	equire en sig ould b			1 🗆	Yes 2 No 3□	Probably 4 Unknown
Records,	law r nas be e 2 sh	Completed		24a. Was auto	psy prior to	autopsy findings available completion of cause of
				1□ Yes	ormed? death′ 2 No 1 □ Ye	
Vital	ysicia s certi directo	o Be	examiner? Hospital: Other:	ath <i>(Check only o</i> Home 5 □ Resi	one) dence 6 ⊡Other (St	necify)
Division or	ding Phys n. After this funeral dir	L I	27. Manper of Death 1	1	how injury occurred	
SIO	ttendil leath. tor: A the fu	catic	2 Accident investigation M 1 Yes 2 No	206 Lagration (	Chant and Number or	Burnt Boute Mumbor
	I or Attend after death Director: ,	Certification:	4 ☐ Homicide determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	Street and Number or wn, State)	nurai noute Nurriber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier  (Check only one)  Check only one)	urred at the time.	date and place, and d	ue to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
)			MAJallum D26388		July 12,	2007
			29b. Signature and title of certifier  29c. License number	Herloci	kmd 21	643
9	Sta Registr	- 1	31. Date filed (Month, Day, Year)  JUL 1 6 2007			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 15, 2007 0509 Donald Ε. Baker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-21-1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1)X M 2□ F Months Days Hours Director Maryland 72 215-32-6502 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director MD Wicomico Salisbury with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 305 Naylor Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 200 No Specify: Specify. If Yes, Give Year or Dates: 1953-55 by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Master Plumber 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H 7 is marked ot Catherine Louise Long James Edward Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 15 Edgewood Drive, Berlin, MD 21811 Donna Baker/Daughter other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: if it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Garl 7/19/2007 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Arvic 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death phalogathy Immediate Cause (Final **Physician** 10 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Dav Year 4 Pregnant at time of death 5 Other (specify) Ö þ σ. signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll Street, Salisbury, MD 21801 James Trauger 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

JUL 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23,27,28a f per me, 2870,08/02/07dhb

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 14:28 PM Butler 10 William JUly /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner VA Bultimore Bultimore Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Mín. 1 M 2 □ F Days Months 031-12-7879 Mass Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Hampshire Directo Augusta 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 26704 HC-71 Box 202 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 DX es 2 No If Yes, Give Year or Dates: 1944 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Wever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Farm Manager Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H I item 27 is marked off Be Lillian Kavanagh <u>Henry Butler</u> P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 190 High St. #508 Medford, Mass. 02155 Mary Butler (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/13/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cresaptown, MD 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli F. H. PA 22. Name and Address of Facility 21. Signature of Funeral Service Licen McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hematoma Subdural **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physicien and for use as the burial-translt or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို TX Yes 2 19 No this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Watural 5 Pending 1 ☐ Yes 2 ☑ No Multiple falls investigation Unknown Unknown M 2 Accident the ector: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office \_building, etc. (Specify) filled in by 4 Homicide within 24 hours efter To the Funerel Dire Unknown Unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 10, 2007 1711032

Registrar

State

Jiakan

31. Date filed (Month Pay, Year)

Course

10 N. Greene St. Bultimore MD 21201

30 Name and address of pers in who commeted cause of death (Item 23a) (Type, Print)

2007

M.D.

32 Registrar's Signarde

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 25,27,28a-f per me 2870,08/02/07/hb

Regular 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Lillian Esther Bowen June 21 2007 715 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Calvert Prince Frederick 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 92 Director 216-12-4467 Aug 24 1914 Maryland Usual Residence of Decedent be filed within 72 nouse and Hygiene.
Intal Hygiene.
Ind other than "natural" or items 23a or 28a-f show
sed other than "natural" or items 23a or 28a-f show
c event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland | Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4915 Sandy Point Road 20678 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ⊋No Specify Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) supervisor/housekeeping Calvert Memoiral Hospitla is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Hal Bowen Carrie Esther Weems 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum Dorothy L. Bowen- sister 4915 Sandy Pt. Rd. Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery June 25 2007 Barstow Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home Drawsc 20676 Approximate Interval Between Onset and Death 4405 Broomes Is. Rd. Port Republic MP diac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Allund /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or burial-tran and Due to (or as a consequence of): CERTIFICATION APPROVED Box 68760 attending physician Physician/Medical as the IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> Advance 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1∐ Yes Vital 2 **N** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Ö funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation Division Hospital or Attending June 11,2007 Unknown 1 Natural Subject fell out of bed 1 ☐ Yes 2 No 2 Accident
3 Suicide 24 hours after death Prineral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) **85 Hospital Rd.** 4 Homicide Nursing Home Prince Frederick, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical прletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ D0052242 June 22 2007

DHMH 17 Rev 1/2001

State Registrar

ME

J. John Barth, III, M.D. 110 Hospital Rd.

Registrar's Signature

Prince Frederick MD 20678 Suite 310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 0 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 6:00 AM ľĨ 2007 /Medical 4a. Facility Name (If not institution, give street and number)
6123 North Hill Har 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Circle George If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex: 1 M 2 □ F 8. Date of Birth (Month, Day, Ye 7. Age (In yrs. last birthday) **Funeral** Days Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Na Yes 2 No If Yes, Give Year or Dates: 63-65 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BOOK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Tech Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Cypress ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20147 19a. Informant's Name/Relationship North Hil Har circle Forestville HD Wife 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify) Suffland Haryland 3 □Removal from State 27/07 incoln Hemorial 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy
performed?

1 Yes 2 No death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
12 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date, signed (Month, Day, Year) 30. Name and addre is if person who completed cause of death (Item 23a) (Type, Print) Crystal Yelvell, M.D. 5100 Auth Way Camp Springs, Md. 20748 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

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20a. Method of Disposition   1Memind of Disposition   1\text{Memind of Disposition	059
4a. Facility Name (if not institution, give street and number)  Herritage Harbour Health & Rehab Center  Annapolis  5. Social Security Number 214-26-5922  10 M 20 F 7. Age (in yrs. last britingly)  10 By Yrs.  10 By Yrs.  10 By Yrs.  10 By Hours Min.  10 By Gittzen of What Country  10 Linkers  10 By Gittzen of What Country  10 Linkers  11 By Mas Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin. Mescar, Puerto Ricker, etc.  11 By Hours Min.  11 By Mass Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin. Mescar, Puerto Ricker, etc.  11 By Hours Min.  12 By By Hours Min.  13 Was Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin. Mescar, Puerto Ricker, etc.  14 By Hours Min.  15 By By Hours Min.  16 By Citizen of What Country  16 By Citizen of What Country  16 By By Min.  16 By Citizen of What Country  16 By By Min.  17 Feather's Name (First, Middle, Last)  18 By Mass Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin. Mescar, Puerto Ricker, etc.  16 By By Min.  17 Feather's Name (First, Middle, Last)  18 By Mass Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin.  19 By Mass Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin.  10 By Mass Discodert of Hispanic Origin? (Specify Yes or No. In The Social Specify Cubin.  10 By By Min.  11 By Mass Discodert of Hispanic Origin	Death A M
214-26-5922   1   M 280 F 89   Yrs.   Months   Days   Hours   Min.   July 4, 1918   Virginia	
10a. State   10b. County   10c. City, Town or Location   10d. Inside C   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120	Foreign
1914 FOTEST DITVE, #ZAN   12 Was Decedent Ever in U.S.   13. Was Decedent Hispapine Origin? (Specify Yes on No-Indian Hispapine Origin?)   14. Race - American Indian.   15. Decedent Education (Specify only highest grade completed)   12 Wes 22 Man   12	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseases or condition resulting in death)  Dementia  Dementia  Due to (or as a consequence of):  Due to (or as a consequenc	
19. Feither's Name (First, Middle, Last)   18. Modifier's Name (First, Middle, Maiden Surname)   18. Modifier's Name (First, Middle, Name (First, Middle, Name (First, Middle, Name (First, Middle, Name (First,	
18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (First, Middle, Maidens, Maiden	
198. Informant's Name/Relationship (Type, Print)   199. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zie Code)   1914 Forest Drive, Suite 2A, Annapolis, MD 21   20a. Method of Disposition   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   120   12	
1 XBurial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)	01
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dementia disease or complications that cause of the death of the disease or complications that cause of the death of the disease or condition resulting in death)    Dementia	nd
Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause decedent pregnant in the past 12 months?  1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Coronary Artery Disease  Hypertension  24a. Was an autopsy performed? 1   Yes 2 No 3   Probably 4   Part II. Yes 2 No 3   Probably 4   Part I	
Coronary Artery Disease    1   Yes   2X No   3   Probably   4	'ear
25. Was case referred to medical examiner? 1   Yes   25. Was case referred to medical examiner? 1   Yes   25. Was case referred to medical examiner? 1   Yes   25. Was case referred to medical examiner? 1   Test   26. Place of Death (Check only one)    Other: 422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422   422	
examiner?    Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4XXViursing Home   5   Residence   6   Other (Specify)	vailable use of
27. Manner of Deam    27. Manner of Deam   28d. Date of Injury   28d. Time of Injury   28d. Injury	ber,
29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	)
29b. Signature and title of tentilier  29c. License number  D0051897  29d. Date signed (Month, Day, Year)  July 17, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Njide Udochi, MD 9055 Chevrolet Drive, Suite 100 Ellicott City, MD 210	12
31. Date filed (Month, Day, Year)  32. Resistrar's Signature  32. Resistrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Resistrar's Signature  36. Resistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**  $P^{M}$ Joseph George Ciufolo 2007 2:30 July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Woodbine 3606 Woodbine Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours Months 1√2 M 2□ F 85 577-12-0761 June 28,1922 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Howard Woodbine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21797 3606 Woodbine Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married White 1343 1 ☐ Yes 2 X No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing **12** Lithographer ages 1 and 2 should be filed out of Health and Mental Hygin to If Item 27 is marked other y or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adelina Testa Luigi W. Ciufolo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Avon Ciufolo / Wife 3606 Woodbine Road, Woodbine, MD 21797 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 cemetery, crematory or other place
Parklawn Memorial
Park\_ 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or once. July021 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 22. Name and Address of Facility DeVol Funeral Home 10 Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Licens East RACU Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s autopsy performe certificate 1□ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2**[7**] No 1 Inpatient 2 this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? A er t Certification: (Month, Day Year) Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 Physician: To the Hospital or Attendi within 24 hours are death. To the Funeral Director: A

Baltimore, Maryland 21215-0036

0+1

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23 2007

WD

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D35635

29d. Date signed (Month, Day, Year)

July 20, 2007

		1 - State Certificate of Death		Reg. No	0.	7 2506
Dhunin	:	1. Decedent's Name (First, Middle, Last)	2. Date of Month	f Death Da	av Yea	3. Time of Death
Physic /Medi		Betty Coniglio		y 21,		8:15 a
Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D	Death	40	c. County of De	eath
		Hebrew Home of Greater Washington Rockville			Monto	gomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		Birth	9. 6	Birthplace (State or Fore
Director		579-62-8176 1 M 2 F 91 Yrs. Months Days Hours 1	Min. (Month) Feb.	, Oay, Year 27 1		Country) Michigan
		Usual Residence of Decedent	TED.	21, 1	510 1 1	nicurgan
vlend ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Lim
Man f	ō	Maryland Montgomery Rockville				1 ☐ Yes 2 🔀
28a	ec	10e. Street and Number 10f. Zip Code		10a C	itizen of What	Country?
F 0 8	급			. og. 0		
eff.	a	6105 Montrose Road 20852			USZ	
72 hours after deeth with the Marylend natural; or Items 23a or 28a-f show digal Examinar most be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	n? (Specify Yes o Puerto Rican, etc.	r No-	14. Hace - Al Black, W	merican Indian, hite, etc.
affe of		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify:			Specify: W	nite
ours	9	3 Midowed 4 □ Divorced Year or Dates:			-/>. AAT	11.00
72 h	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	f workina	16b. l	Kind of Busine	ss/Industry
within ene than	효	Elementary/Secondary (0-12) College (1-4or 5+)				
gien Frth	5	9 Homemaker			Own I	Home
Hygie other	Be (	17. Father's Name (First, Middle, Last)  18. Mother's	Name (First, Mic	ddle, Maide	n Sumame)	
ked o	ToB	John Vitale Conce	etta Oli	vieri		
should a marke umatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of				a. Zip Code)
han han 7 le		Mary Ann Monto/Daughter 17809 Shotley Bridge				
s 1 and 2 should be hied within 72 hours after deem win the Marylen if Heelin and Mental Hygiene. If Heelin and Mental Hygiene. Other treumatic event, the Medical Examinar must be notified at			Date Date			····
		1 XBurial 2 Cremation 3 Demoval from State cemetery, crematory or other place)	July 24		Location - City	or Town, State
Page Page Page Page Page Page Page Page		`4 □Donation 5 □Other (Specify) Gate of Heaven Cemetery	2007	. 1	lver S	oring, Mary
permit. Page: Depertment or Importent: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collis				
Deperming of the service of the serv	1					
	-	500 University F			ver so	ring. MD ZU
		23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as car			_	Approximate
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call shock, or heart failure. List only one cause on each line.			1	
		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	rdiac or respirato	ry arrest,		Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 8:30 P M July 12, Jannie Eva Cartledge 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9612 Small Drive Prince Georges Clinton, Maryland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 TF Director 250-62-8966 McCormick, SC July 1, 1930 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland | Prince Georges Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9612 Small Drive 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Private permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If item 27 is marked any Injury or other 1000. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk Jack Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellihue Cartledge / Husband 9612 Small Drive, Clinton, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cedar Hill Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 37/19/2007 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD apr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIOMY01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPERTENSION death certificate be executed burial-tran Due to (or as a conseque Box 68760. physician Physician/Medical the ası attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Ö been signed by the should be detached 9 Unknown نم Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No has  $\alpha$ page certificate Division or Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death
Natural
2 Accident 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending within 24 hours after use....

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier kulin M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURMATTS ROAD #307 CUNTON MD VENKAT. S. KAMANAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 3 2007 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health  1 - State Registrar  State of Maryland / Department of Health  Certificate of Death			ene 3. No. 200	7 25062
**	Physici	an	Decedent's Name (First, Middle, Last)	l N	ate of Death	Day Year	3. Time of Death
	/Medic	al	Gladys E. Coates  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		ly 12,	4c. County of De	2:00 aM
	Funeral		Clinton Rehab & Nursing Home Clinton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		ate of Birth	9. B	Georges
	Director		577-48-3723 1 M 2 F 72 Yrs. Month's Days Hours	Ju	ne 20,	1935 Was	shington, D.C
	ryland how Lat		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Ma 28a-f s outified	ecto	Maryland Prince Georges Temple Hills  10e. Street and Number 10f. Zip Code		100	g. Citizen of What 0	1 ŽiYes 2 No
	h with 23a or st be r	al Dir	2617 Oxon Run Dr. 20748			United St	
0000	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces  1 □ Yes 2 □ No		Yes or No- n, etc.)	14. Race - Am Black, Wh Specify:	
N-C171	vithin 72 hou ine. ihan "natura ie Medicai E	Completed			10	6b. Kind of Busines	
2	filed v I Hygie other t	Be Co	17. Father's Name (First, Middle, Last)  Computer Assist  18. Mot	tant other's Name (Firs	st, Middle, Ma	Governme aiden Surname)	enc
yland	ould be Menta arked atic ev	To B	Tommy Edmonds Ar	nna J. J			
N N	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print)  Jacqueline D. Morgan/Daughter  2617 Oxon Run Dr.				, <i>Zip Code)</i> 0 <b>74</b> 8
more,	Pages 1 ar nent of Hea int: if item iny or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Maryland Veterans	July 20,		oc. Location - City o	
	permit, Departn Importa any injt		I MAN OF FRANCES			ville, Md	. 20747
	hysician		23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Cervical Cancer	as cardiac or res	piratory arres	st,	Approximate Interval Between Onset and Death
	/Medicai Examiner		resulting in death)  Due to (or as a consequence of):  Diabetes Mellitus				
91	9 9 H	iner	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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O. DOX 0	The Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending picompletely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2.	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of d Month	lelivery Day Year
cords, r.	juires that I signed by Ild be deta	þ	Panal Failure	art I.			to the cause of death?  Probably 4 \textstyle Unknown
Deco	The law recate has been page 2 shou	Completed	Anemia		24a. Was an autopsy perform	prior to	
<u> </u>	siclan: certific rector,	Be	25. Was case referred to medical examiner?	ace of Death (Ch			
SIOII OF	ding Phys h. : After this funeral di	tion: To	1   Yes 2   No   Nospital 1   Inpatient 2   ER/Outpatient 3   DOA   Other 4   1   1   1   1   1   1   1   1   1	28d.		nce 6 □Other (Sp v injury occurred	Decity)
	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Stre City or Town,	eet and Number or State)	Rural Route Number,
	he Hospit n 24 hours he Funers pletely fille	edical	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, date and manner stated.				
	withi To ti	M	29b. Signature and title of certifier 29c. License numbe	er		d. Date signed (Mo	
/	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			July 17,	2007
1	5 (5)		9801 Georgia Ave. 3-41 Sil	lver Spr	ing, M	d. 20902	2.
	Sta Registr		31. Date filed (Month, Day, Year 32. Registrar's Signature Specific				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23ptII 25 27,28a-f. per me 8879 5-6-08 vt. State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 26 2007 10:00 A M Michael Joseph Driscoll /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner South River Health & Rehab. Center Anne Arundel Edgewater If Under 1 Year | If Under 24 Hrs. 6. Sex 1X M 2 ☐ F 8. Date of Birth (Month, Day, Year 07/04/1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 86 Washington, D.C. Director 579-16-9378 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2 No Director Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 United States 700 Americana Drive, Apt. 53 Funeral 2. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1942-46 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 【XNo Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Joseph Driscoll Florence C. Barbee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Dean/Niece 4804 Lincoln Avenue, Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 08/04/2007 Washington, D.C. 21. Signature of Fund al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. Ulkl 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** and iac /Medical as a consequence of) Examiner APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATIO attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Right Hip Fracture 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 XYes 2 Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation Subject Fell 1 ☐ Yes 4-25-2007 2:00 a<sup>M</sup> 2 Accident Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 700 Americana Dr. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Md. Annapolis, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only 24 and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raj Chawla, 14300 Gallant Fox Lane, Suite 210, Bowie, Maryland 20715 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05595 State of Maryland / Department of Health and Mental Hygiene Jeff Dunn Certificate of Death 1- For State Reg. No. Registrar Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 21, 2007 0530 hrs Medical Examiner JEFF REY tc. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicdmicd Peninsula Regional Medical Center Salisbury 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Hours Country) Director 2 F Yrs 1 X M Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a. State 10b. County Yes 2 No 28a-f show WICOMICC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number GE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Never Married 2 X No Yes Specify: WHITE Yes 2 KNo specify: If Yes, Give Yeer Widowed Divorced the Medical Examiner ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Flementary/Secondary (0-12) MMERCIAL 18. Mother's Name (First, Middle, Maiden Surname) marked other 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State 2 Cremation 3 Donation 5 Other Specify: 21. Signature of Funeral Service License KEK Part LE her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death 1edical a Cirrhosis of liver Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransit sician/Medical X UNPENDED X AMENDESa, 27, penME, g870, 8/13/07 TT attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Day Month 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 🗸 Unknown ò 24b. Were autopsy findings available Completed 24a. Was an Records, this certificate has been all director, page 2 should prior to completion of cause of autopsy performed? death? ✓ Yes No ✔ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 2 V ER/Outpatient 3 Inpatient 1 V Yes

Division of Vital

27. Manner of Death

Accident

Suicide Homicide

29b Signature and title of certifier

31. Date filed (Month, Day, Year)

Patricia Arnnica-Pollak MD.

1 X Natural

29a. Certifier

Certification

Medical

State

Registrar

filled in by the

200

30. Name and address of person who completed cause of death (Item 23a)

Pendina

Investigation

Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated

Assistant Medical Examiner

gistrar's Signatur

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28d. Describe how injury occurred

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

July 22, 2007

29d. Date signed (Month, Day, Year)

28c. Injury at Work?

Yes 2

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 250 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year PM Thomas William DeMoss JUL 91 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County 6. Sex 1 X M 2 ☐ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Vear 494-74-5724 45 1962 California Director 9 May Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes X ☐ No Maryland Washington Funeral Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? One Harvard Road 21742 U.S.A. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Credit Card Company Customer Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David William DeMoss ပ Joanne Colvig Zebarth 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannie Rose DeMoss - wife One Harvard Road Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery July 27 07 | Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any leafing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physiciar Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) been signed by the a should be detached 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 101 lemia 1 ☐ Yes 2 ☐ No 2/Z/No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2月 No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1- Natural Injury To the Hospital Control within 24 hours after death. To the Funeral Director: After the Funeral Director of Control of the figure of the figu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

M-5 State

SANIAY Saxena 31. Date filed (Month, Day, Year) 2 5 2007

1138 Ofal C+.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

0-0056413

Hagerstown, MD 21740

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Dorothy Joan Dyer 10:55P<sup>™</sup> IIII.Y21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Nursing & Rehab Center Rerlin 8. Date of Birth (Month, Day, Yea 6/13/1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 79 Director 216-22-4237 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD Worcester Ocean City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21842 12628 Sheffield Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2K No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paper Company Secretary filed marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental Agnes Fabula Peter J. Myszkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Vincent Molloy / nephew 273 Pinewood Rd., Millersville, MD 21108 27 Department of Health Important: If Item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Mem. 7/25/2007 Baltimore, MD 21. Signature / Funeral Service Lic 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Moulus Immediate Cause (Final disease or condition resulting in death) Netastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) o ed by the a 9 Unknown 9 Unknown ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Dhknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier t 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) en wet Ishal, De 19944 1209 reliala FE 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

23

2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5=04 PM 20,2007 Melva Jean Damewood JUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Westminster Carroll Hospital Center 8. Date of Birth (Month, Day, Year) Nov 02 1936 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 □X€ 70 MD Director 214-34-1883 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at MD Carroll Westminster 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 324 E. Main Street 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Bittinger William Green ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Damewood/husband 324 E. Main Street Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/23/2007 permit. Pages Department of Inportant: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 Donation 5 Other (Specify) 21. Signatur of Juneral Service L Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOMA OF THE LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any sequentially limited access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760. within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. the Hospital

Saltimore, Maryland 21215-0036

WSL 3

Medical

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D. CARROLL I 31. Date filed (Month. Day. Year) JUL 2 4 2007

29b. Signature and title of certifier

A. J Helory M. D.

(Check only one)

em 23a) (Type, Print) 200 MEMORIAL AVE. CARROLL HOSPITAL CENTER, WESTMINSTER, MD 32. Registrar's Signature

Elver & Spark

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Doo 17695

July 20, 2007

		•	For State Registrar	St	ate of Ma	ıryland	-	artment of the tificate of	Health and I Death		Reg. No.	:007	25068	
	Physicia /Medic		1. Decedent's Name (First, Midd	le, Last)	YOE					2. Date of De Month	aath Day	DÖĞ	3. Time of Death  5:50 A M	
	Examin		As the life and the state of the state of the state of and state of the state of th						4b. City, Town, or Location of Death Walkersville			4c. County of Death Frederick		
	Funeral Director		5. Social Security Number 083-32-3421	6. Sex 1 ☐ M	7. Age		st birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, Di Aug 30	rth ay, Year) 1909	Co	hplace (State or Foreign unity) York	
	aryiand show	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County	/		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 📉 No	
1	28a-f	Director	MD Frede  10e. Street and Number	rick		Fred	erick	10f. Zip Code			10g. Citiz	en of What Co		
1	23s or	alDi	5955 Quinn Orc	hard R	load			21704			USA			
200	s I and 2 should be lied within 72 hours after beath with the maryand. If Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	rried 1	Vas Decedent E Amed Forces? ☐Yes 2XXN fYes, Give /ear or Dates:			Was Decedent of f Yes, specify Cub 1 ☐ Yes 2 🖾 No	Hispanic Origin? (Span, Mexican, Puer Specify:	pecify Yes or Note 10 Rican, etc.)		4. Race - Ame Black, White Specify: Whi	e, etc.	
מים ביו	nen "nature	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12)	1	n <i>npleted)</i> Coll <b>e</b> ge (1-4or 5		(Give life. L		i during most of wo ad)	rking	16b. Kin	d of Business/		
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9 (			19a. Informant's Name/Relation Howard Jossely						t and Number or Re illings R					
и.	permit. Pages I and a Department of Health in Importent: If Item 27 I eny Injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		val from State	ce	metery, cren sapeak	esition (Name of matory or other pla ce Cremat	ory 07/	Date 25/07	Be1t	sation - City or sville,	MD	
Dall	Departr Departr Import eny Inji		21. Signature of Funeral Service	Licensee	Otte	mola	2.5/ Be	Name and Addroing Home	ess of Facility Cremati Heckrot	on Servi	ice • Cla	P.O. Borksvill	ox 784 Le, MD 21029	
F	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  Approximate Interval Between Onset and Death 3 - 4 Do-y											
	/Medical Examiner		resulting in death)		Due to or as	a consequ	ience of):						1	
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cords, P.	quires that on signed by uld be detail	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause  1   Yes 2   No 3   Probably 4											
	ine taw re sete has bee page 2 sho	Completed	/	45:						24a. Wa auto per 1 Yes	opsy formed?	24b. Were au prior to death?	utopsy findings available completion of cause of	
N	certific rector,	Be	25. Was case referred to medic examiner?	al Hosp	ital:		- D/O			ath (Check only				
VISION OF	to the rooping of Attending Physician: The law within 24 bounds after due to within 24 bounds at the this certificate has completely filled in by the funeral director, page 2 or	ation; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend 2 Accident inves		8a. Date of Injur (Month, Day	ER/Outpatient 3 DOA Other: Wursing Home 5 Residence 6 Other (Specify)  28b. Time of Injury Mork?  M 1 Yes 2 No						cny)		
	lei or Atte s after des el Director ed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)					e, farm, street, factory, office  28f. Location City or				on (Street and Number or Rural Route Number, r Town, State)		
;	to the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical												
i	vithii To th	Σ	29b. Signature and title of certification	ier	_				nse number		29d. Date	signed (Mont	th, Day, Year)	
	60		30. Name and address of perso	Horen n who compl	eted cause of d	hoh leath (Item	23a) (Type.	Print) Lie	5/643 ren Sha	<i>a</i> b	7/	4107		
	EĞ		65 C Tho	nas	The		m 2	& Lela	dend	× mo	21	702		
	Sta Registi		31. Date filed (Month, Day, Yea	5 2007	32. Registra	ar's Signa	lure A	book						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#4a&26, perMD, 7/25/07, DPS, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Dickerson Virginia Mae 18,2007 6:00a July /Medical 4a Facility Name (If not institution, give street and number)
Kensington Park Hetirement Community 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3620 Littledale Road #105 Kensington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 262-40-1896 77 Wash., D.C. Director 4/03/1930 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at FL. Manatee 1 X Yes 2 □ No University Park Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be r 34201 Court 8131 Abingdon USA Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roessle William R. Gillespie Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9014 Fairview Road Silver Spring, Md 20910 David Dickerson/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/19/2007 Beltsville, Md. Chesapeake Crem 21. Signat red Funeral Se vir e Licensee PHILIP O. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 18 mo. Small Cell Lung Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one)
Other:
4 Nursing Home 5 Residence 6 Other (Specify SSISTED) Be examiner 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: living Hospital or Attending 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical pletely (Check only one)

Within 24

Registrar

Joseph M.Haggerty MD 31. Date filed (Month, Day, Year)

JUL 23 2007

Joseph M. Haggerly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

9707 Medical Center Dr. Rockville, Md 20850

29c. License number

D32407

29d. Date signed (Month, Day, Year)

July 18,2007

		-	For State Registrar	of Maryland	•	rtment of H tificate of L			eg. No.	0117	25070	
€	Physicia	an	Decedent's Name (First, Middle, Last)	•			2. Date of Deat Month	Day	Year	3. Time of Death		
	/Medic	al .	HAZEL BARKER DEL 3  4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death			15 4c. Coun	2007 ty of Death	10:05 P <sup>M</sup>		
	Examin	er	10316 Crestmoor Drive		Silver Spring			Montgomery				
	Funeral Director		5. Social Security Number   6. Sex 1 ☐ M 2 ☑	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 15	Year)	9. Birthp Coun	lace (State or Foreign try)	
ī	pu »		Usual Residence of Decedent  10a. State 10b. County	10c, City,	Town or Loc	eation				1	0d. Inside City Limits	
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	h with	a D	10316 Crestmoor Drive			20901	_		U.S.A	Α.		
	s 1 and 2 should be filed within 72 hours after death with the Marylan ff Health and Mental Hyglene. If Health and Mental Hyglene "natural", or items 23a or 28a-f show them 21s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	Arme 1 □ Never Married 2 □ Married 1 □ Yes	Decedent Ever in U.S. d Forces? es 2 🔀 No , Give or Dates:		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 12 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	В	ace - Americ lack, White, cify: Whit	etc.	
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	12 sh h and 7 is rr traum		19a. Informant's Name/Relationship (Type. Print)			g Address (Street			-			
ב ע	ages 1 and 2 nt of Health : If item 27 i	1	Donna M. Brennan/Frie 20a. Method of Disposition			sition (Name of natory or other place			20c. Location		yland 20901 own, State	
allillo	Pages nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	om State	e Of H	leaven Ce	me. 07/2				ng, MD	
סמו	permit. Pages 1 Department of H Important: If ite any Injury or ot once,		21. Signature of Funeral Service Licensee	t	·   22 H]	Name and Addre	ss of Facility LDI FUNE: Hampshir	RAL HOME	, INC.	Spring	MD 20904	
	Physician /Medical Examiner		resulting in death)	nat caused the death. on each line.  tamous Cel to (or as a conseque	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death 2 Years	
The law requires that the death certificate be executed	icate be executed physician and sthe burial-transit	edical Examiner										
	w requires that the death certifics, been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	y			Date of delive	ery Day Year				
C, C	uires that signed bid be deta	by	Part II. Other significant conditions contributing		e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown							
Records	The law req	Completed						24a. Was a autop: perfor 1 Yes	un 24 sy med? 2 ☑ No	b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of	
<u>a</u>	ctor,	Be (	25. Was case referred to medical examiner?			l an		th (Check only or	ne)			
Jo uc	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	은	1 Yes 2 No No No Note: 1 Inpatient 2 ER/Outpatient 3 DOA Outer. 4 Nursing Home 5 Residence 6 Other (Specify)								<u>'y)</u>	
LIVISIO	arer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within 2 To the comple	Med	29b. Signature and title of certifier	manner stated.		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)	
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	10		30. Nam, and address of person who completed	Ilis, MD.	1080	Print) 1 Lockul	ood Dri	ve; Si	ver Sp	ring;	MD 20901	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signar	y A	and I		)		))		

			1- For State of Maryland / Dep	artment of Health and Martificate of Death	lental Hygiei Reg.	2001 2001				
8.	Physici /Medio		1. Decedent's Name (First, Middle, Last) Allen DICKSON		JUTP 19,	<sup>2</sup> 2007 Year 3:42 A N	1			
\$1. \$4.	Examir		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4c. County of Death Montgomery						
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye March 25,	9. Birthplace (State or Foreign Country) 1971 Maryland	ר			
	ow at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or U 10c. MD Prince Georges Adelph:	ocation		10d. Inside City Limits				
	8a-f sh	Director				1 ☐ Yes 2 📉 No	)			
5-0036	with the or 2	Dire	10e. Street and Number	10f. Zip Code 20783	10g.	Citizen of Whal Country?				
	leath	era	2202 Muskogee St .  11. Marital Slatus 12. Was Decedent Ever in U.S. 13		ecify Yes or No-	14. Race - American Indian,	_			
	ilied within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23s or 28s-1 show inti. The Wedical Examinar must be notified at	by Funerai	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No  1 Ves 2 No  1 Yes 2 No  1 Yes 6 No  1 Yes 7 Or	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, etc. SpecifyWhite				
	"natur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Industry				
12	withir iene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	nager		Restaurant				
힏	e filed al Hyg othe vent.	BeC	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	den Sumame)				
Sa	ould b	P <sub>D</sub>	Michael Dickson		delman					
Z Z	nd 2 sh alth and 27 is m r traun		1 1 1 1	ing Address (Street and Number or Rura Muskogee St., Adel						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show with fourly or other traumatic event. The Wadical Experiment must be rediffied at ance.		20a. Method of Disposition  1	osition (Name of pratory or other place) July 20	),2007 A1	Location - City or Town, State exandria, VA				
	permit. Departm Imports eny Inju			2. Name and Address of Facility Tol 254 CArroll St., NV	•	Hebrew Funeral Home ston, DC 20012	į			
· (1)	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Acute Respiratory feeling.  Due to (or as a consequence of):  Acute Respiratory feeling.  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to as a consequence of):							
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	dicai Examiner		٠						
	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   4   Pregnant at time of death 5   9   Unknown   5	23d. Date of delivery Month Day Year						
	w requires that been signed b should be deta	Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Nunknown						
Records,	The law re- ate has bee page 2 sho				24a. Was an autopsy performed		8			
Vita Vita	ilcian: Th certificate rector, pag		25. Was case referred to medical examiner?  Hospital:	Other	(Check only one)					
ō	Phys or this sral dii	5 T	27. Manner of Death 28a. Date of Injury 28b. Time	ant 3 DOA 4 Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
on	Attending Physician: ir death. ector: After this certifica by the funeral director, i	atio	1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Work?  M 1 ☐ Yes 2 ☐ No						
Division of Vital	o after	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by	edical (	29a. Certifier (Chack only one)  Certifying Physician: To the best of my knowledge, deal of the control of the	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
)	To the Youthin To the Comple	Me	29b. Signature and title of certifier  Kennedy Zelfert	29c. License number	29d.	Date signed (Month, Day, Year)				
	4		30. Name and address of person who completed cause of death film 23a) (Type James Kennedy Lightfoot, Jr., MD 7600	Print)  Carroll Ave., Tak	Oma Part	MD 20912				
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signalure	Conti	Talk to	and the state of the				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month 2 d TPM Juli 2007 Clyde Edward Ensminger 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Hours 1**X** M 2□F Yrs 87 April 18 1920 Maryland 217-09-9760 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 355 West Side Avenue 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Foreman Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie A. Palmer Elden W. Ensminger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24483 Camp Lake Road, Brainerd, Minnesota 56401 Robert D. Ensminger - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beautiful View Cem. State Line, MD. 7/30/07 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 本15 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS DAYS Due to (or as a consequence of) NEUMONIA Due to (or as a consequence of) ADVANCED D COMBON TUP Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

attending physician

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate has

After this

filled in by the

To the Hospital or Attende within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

Examiner

Be

Certification: To

Medical

Injury or other traumatic event,

**Physician** 

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

ģ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical þ Completed

performe

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

1/X/Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be

1 🗖 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

3□ DOA 2 ER/Outpatient 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1190

GITAZALA 31. Date filed (Month, Day, Year) 2

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

DHMH 17 Rev 1/2001

		ì	For 1 - State Registrar	ase			land / Dep <i>Ce</i>	artme		lealth	and M	•		e'		2507.
	Physici /Medic		Decedent's Name (First, Mi	ddle, Las		RA MAR	RTHA ELL	IS				2. Date of D Month July	Da	2, 200	ear 7	3. Time of Death 5:20 A M
	Examir		4a. Facility Name (If not instituted College View			ımber)			ity, Town, o		of Death			County of		:k
	Funeral Director		5. Social Security Number 177–20–2728	6. S	<sup>вх</sup> □м 2 <del>∏</del> F	7. Age (In	yrs. last birthday 81 Yrs.	) If Un Mont	der 1 Year hs Days	If Unde Hours	Min.	8. Date of B (Month, L Aug •	Dav. Year	9. 925 Pe	Birth Coul	olace (State or Foreign ntry) sylvania
	yland how		Usual Residence of Decedent  10a. State 10b. Cou	nty		100	c. City, Town or L	ocation	<u> </u>							10d. Inside City Limits
	8a-1 s	ctor	PA Buc	ks			Bensaler								1 Yes 2 No	
	with the	Dire	10e. Street and Number 4377 East Yate	ac R	oad			10f.	Zip Code 1902	20			10g. C	itizen of Wha U.S.		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important; if Item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at another.	by Funeral Director	11. Marital Status  1 Never Married 2 N  3 Widowed 4 Divor	larried	12. Was Dec	orces? 2 No ive	in U.S. 13.					ecify Yes or N Rican, etc.)	No-	14. Race - Black, '	Ameri White,	
2-0	72 hou		15. Dece	ient's Ed	ducation 16a Deced				Isual Occup	ation	est of work	ina	16b. l	Kind of Busin	ness/In	dustry
21215-0036	d within giene.	Completed	Elementary/Secondary (0-1			(1-4or 5+)	life.		work done Tuse retired emake		SI OF WORK			Own H	ome	
Maryland	12 should be filed within n and Mental Hygiene. Fis marked other than "raumatic event, the Me	To Be (	17. Father's Name (First, Midd Isaac Massey	ile, Last)								e (First, Midd Irons	le, Maide	n Surname)		
	and 2 sho salth and n 27 is mu		19a. Informant's Name/Relati Peter M. E11:	' '				-						y or Town, State, Zip Code) ry1and 21756		
Baltimore,	Pages 1 nent of He int; if iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 4 ☐ Donation 5 ☐ Other			State	Ob. Place of Disp cemetery, cre Smithsbu	matory	or other plac			Date 3/07		ocation - Cit		own, State Maryland
Balti	permit. Depertrimports any inju		21. Signature of Funeral Serv	ce Licen	SAA JA	Out	A i	2 Name	and Addre	ss of Faci DAIL	EY &	SON, FU	JNERA	L HOM	ES,	P.A.
760,	Physician and Asicien and Asicien and Physician and Physic	l Examiner	23a. Part1. Enter the disea e shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complete or	a. Due to  b. Due to	(or as a con	nsequence of):	nter the r	node of dyir	ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
6876	cate b physic the b	dlcal		•	d				<u> </u>							
P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be deteched for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth 2 🗍 nant at time	Fetal death 3		pregnancy (specify)	/				23d. Date of Month		ery Day Year
	uires that n signed by	þ	Part II. Other significant cond	litions c	ontributing to d	leath but no	t resulting in the	underlyin	ig cause giv	en in Part	I.					he cause of death?
of Vital Records,	he law requir e has been si ige 2 should	Completed										per	topsy formed?	prio dea	r to co	opsy findings available empletion of cause of
tal	vysician: The lavis certificate has director, page 2	மி	25. Was case referred to med	ical			<del></del>			26. Plac	e of Deat	1 ☐ Yes h (Check only		0 1 🗆	Yes	2□ No
Ž	Physici this cer al direc	To B	examiner? 1  Yes 2 No		Hospital: 1 🗆	Inpatient	2 ER/Outpatie	nt 3	DOA Cth			me 5□Re		6 □Other (	(Specii	(y)
Division o	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	2	iding estigation		of Injury oth, Day Yea	ar) 28b. Time (Injury	of M	28c. injur Wor 1 🗀	yat k? Yes 2⊡	]No	28d. Describe				
DIVI	To the Hospital or Attending, within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		4 ☐ Homicide det	benimed	28e. Plac build	ling, etc. (S						City or T	own, Stat	'e)		al Route Number,
	Hosp 24 hot Fune stely fil	edical	29a. Certifier 1 Certi (Check only 2 Medione) Medione	ying Ph cal Exan	niner: On the b	e best of my pasis of exa nner stated.	y knowledge, dea mination and/or i	th occur rvestigat	red at the tir ion, in my o	ne, date a pinion, de	ind place, ath occur	and due to th red at the time	e cause(s e, date ar	s) and manni id place, and	er as s I due t	stated. o the cause(s)
	To the within To the	Me	29b. Signature and title of cer	ifier				29c. License number 29d. Date signed (Month, Day, Yea					Day, Year)			
			> 1h~	e	em t				Doc	60	41>		7	- 23	- 6	フ
	5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									21702					

State Registrar Hemen Shech 1 31. Date filed (Month, Day, Year) JUL 24 2007

DHMH 17 Rev 1/2001

Thomas Johnson

DV, Frederick MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Tiem 4c per dr. 870 08/24/07th

Of Health and Mental Hygiene

			State of Maryland Department of Health and N	lental Hy	/giene	
			1 - State AMEND#10b, perFh, 7/30/07, DPS, MDCb Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No.	3. Time of Death
	Physici		Elizabeth M. Fuchs			12:59A M
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	342)	4c. County of I	Death
_		2.	Renaissance Gardens - Riderwood N. H. Silver Spri			c George's
	Funeral Director		5. Social Security Number  249-28-9411  6. Sex 1 M 2 F  82 Yrs.  1 M 1 M 2 F  82 Yrs.  1 Months Days Hours Min.	8. Date of B (Month, D OCT •	irth (Pay, Year) 20, 1924	Birthplace (State or Foreign Country) South Carolina
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Mary a-f she	tor	Prince George's Maryland Montgomery Silver Spring			1 □ Yes 2 XNo
	ith the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	
	s 23a nust k		3158 Gracefield Road #219 20904  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp			tes of America  American Indian,
136	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must <u>be notified at a the Medical Examiner must be not the Medical Examiner must be not</u>	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton U.S. Armed Forces?  1 Yes, Sive Year or Dates:	Rican, etc.)	Black, \Specify:	White, etc.  Caucasian
9500-612	in 72 hou n "natura Aedical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king		ess/Industry Institute
7 7	ed within /giene. er than " , the Mec	Som	12 Administrative Offi			l Health
/land	be filed votal Hygie	Be			e, Maiden Surname) beth Littl	
Ĕ	2 should be n and Mental Is marked ( raumatic ev	မ	Grover Lynn Martin  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Run			
, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 Is marked any Injury or other traumatic ev once.		Barbara Leonard - Daughter 15914 Attleboro Road;			
ore J	jes 1 g of He if Item or othe		1 Burial 2 MCremation 3 Bernoval from State cemetery, crematory or other place)	Date	20c. Location - Cit	y or Town, State
galtimore,	it. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 0//	27/07	Brentwo	ood, Maryland
g n	permi Depa Impo any l		Hi			ral Home, Inc.
İ	J. 500		23a. Part. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	_Sliver_Sp arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death Years
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  Cardiomyopathy			Years
		ē	Sequentially list conditions, if any leading to innected.  Due to [or as a consequence of]:			rears
	cuted nd ransit	Examiner	Sequentially list conditions, it my list find that cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of the cause			Years
Ď,	icate be executed physician and s the burial-transit	EX	resulting in death) Last  Due to (or as a consequence of):			
28/60	icate b physic the b	dical	d			
ROX	w requires that the death certifing to been signed by the attending I should be detached for use as	In/Me	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date o	f delivery
р Э	the deat y the atte	Physician/M	in the past 12 months?  1		Month	Day Year
7.	that th ed by t detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
SD	requires een sign nould be	d by		1 🗆	]Yes 2□No 3[	☐ Probably 4 X Unknown
ecord	<u>a</u> 85 €	Completed		24a. Wa		re autopsy findings available or to completion of cause of
Ţ	The ate har page	Com		per 1⊡ Yes	formed? dea	th?  Yes 2 X No
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0	g Physer this eral di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		sidence 6 Other and how injury occurred	(Specify)
SION	ending ath. or: Afte	ation	2 Accident investigation M 1 Yes 2 No			
	al or Attus safter de il Directo ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner rated.			
	To th	Ĭ	29b. Signature and title of partition 29c. License number		29d. Date signed (/	Month, Day, Year)
	12		D24993		July 20,	2007
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mark Parkhurst MD 3110 Gracefield Road; Silver Spr	ing, M	D 20904	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	JUL 23 2007 Shows 15 April			

			For State Registrar	State of Marylan		rtment of F		, ,	jiene	25075
ľ	Physici		Decedent's Name (First, Middle, Last)	Lillian M.	Gilmo	ore		2. Date of Dea		3. Time of Death
Ų.	/Medic Examir		4a. Facility Name (If not institution, give s				r Location of Death		4c. County of Dea	
	Funeral Director		Crofton Convales 5. Social Security Number 6. Sex 345-20-4913		last birthday)	If Under 1 Year Months Days	rofton If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	year) 9. Bir	undel  thplace (State or Foreign ountry)  Illinois
	pug ≱		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	eation				10d. Inside City Limits
	shoved at	5			y, 10 mil 01 200					1 □Yes ¾□No
	the N 28a-f	lect.	Maryland Anne A	rundel		Crofto	n	1	log. Citizen of What Co	
	Mith Baor t be	Ö	1432 Knightbrid	ro Turn			21114		U.S.A.	,
	death ms 2: mus	Funeral		12. Was Decedent Ever in U.	S. 13. V		lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 [X]Widowed 4 ☐ Divorced	Armed Forces? 1		Yes, specify Cuba	Specify:	Hican, etc.)	Specify: Wh	
5-0	72 hc natui lical	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	ent's Usual Occup	oation during most of worki d)	na	16b. Kind of Business	/Industry
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121	lled w lygiel her ti nt, th		17. Father's Name (First, Middle, Last)		C	lerk	18. Mother's Name	(First Middle	Drug St	ore
Maryland	t be finital the	Be	,	3 - 3 - 0 - 1	J E			,	•	
2	should nd Me mark matic	မ	19a. Informant's Name/Relationship (Type	dward Schon pe. Print)		a Address (Street		beth I	r, City or Town, State, .	Zin Code)
<u>8</u>	and 2 sealth ar n 27 is		Arlene Linkenhe	· ·	1					60544
<u>6</u>	es 1 and 2 of Health fitem 27 rother tra		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of natory or other place		)ate	20c. Location - City or	Town, State
9	Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			Cem 8/3/	07 8	Alsip, Ill	inois
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service License  Muchael P Pages		22	. Name and Addre	ss of Facility Mar	zullo	Funeral (	Chapel, P.A.
	59.53		23a. Part1. Enter the disease, or comor shock, or heart failure. List only or	cations that caused the deat						Approximate Interval Between
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Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 □	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year
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000	w requir been sl	Completed	Doug O. E.				- <del>-</del>	24a. Was a	an 24b. Were a	utopsy findings available
Re	The la	ᇤ	- Constant		-			autops	sy prior to death?	completion of cause of
tal	an: 7 tificat tor, pa		25. Was case referred to medical				26. Place of Death			3 2□₩0
>	Physician: this certific	To Be	examiner? 1 Tes 2 No	lospital: 1   Inpatient 2	ER/Outpatient	t 3 DOA Oth	ier:		ence 6 □Other (Spe	ecify)
0	ng Ph ter th		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	ry at	28d. Describe h	ow injury occurred	
ioi	Attending r death. ector: After by the funer	atio	2 ☐ Accident investigation	(	,,		Yes 2 □ No			
Division	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S. City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in birth and the completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death ation and/or inv	occurred at the ti	me, date and place, opinion, death occur	and due to the o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To t To t	M	29b. Signature and title of certifier			29c. Licens	102	8 2	7 - 3	th, Day, Year)
•	6		30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type, I	Print)	-	A		
	0		1011	ra MD La	DO This	typely A	trenue ,	Innap	113 MD	21401
	Sta Regista		31. Date filed (Month, Day, Year)  AUG 0 6 200	32 Registrar's Signa	ature	. A		,		
DH	MH 17 Rev 1/2		AUG V 0 200	January A	1. 140					

DHMH 17 Rev 1/2001

### 07-05729 Paul James Gregson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Mandand	Department of Healt	h and Mental Hydlen
State of Maryland	Department of Floar	at all a trottion in go

Private Interest Paral James Gregon  Formal Para				For State		Certi	ficate of	Death					eg. No.		Time of Death
As Pacify Name if call instruction, the served continuous processing of the process			1.	Decedent's Name (First, Middl		s Gregson						Month	Day Y		
Social Section Number   Soci			48		n, give street and n	umber)	4						Cecil		
The state of the s								Months	$\rightarrow$					Fore	ignPennsylvania
The fill of the control of the contr	66 n 72 hours after death with the Maryland an "natural", or items 23a or 28a-f show any ival F vanimer must he motified at once.	Cuperal Director	To Be Completed by Funeral Director	sual Residence of Decedent Da. State 10b. County Iaryland Cec: De. Street and Number  27 Cecil Road  1. Marital Status 1 Never Married 2 N 3 Widowed 4 X Di 15. Decedent's Education (Special Road) 15. Decedent's Education (Special Road) 16. Decedent's Education (Special Road) 17. Father's Name (First, Middle William John 18. Informant's Name/Relation William J. Gr 20a. Method of Disposition	il  tarried 12. Was Do Armed 1 Yes if Yes, Give Yor Dales: ecify only highest gr college e, Last)  Gregson, ship (Type, Print) egson, IV	ecedent Ever in U.S Forces? 2 X No ear ade completed) (1-4 or 5+)  IV  //Father [20b. P	in the second of Disposition of Disposition (Control o	on  e  10f. Zip Cod  2191  s Decedent codes, specify Codes, specify Codes of working the code of the c	9  If Hispauban, No  Supation glife. C	specify:  n (Give ki bo NOT u  B.Mother's  and Numb  R Roa  etery,	ind of wo	cify Yes or Notican, etc.)  ork done ad)  First, Middle,  Louise  ural Route Nu  Elkton  Date	Unite Unite 14.Ri Speci 16b. Kind of Wat Maiden Suma Kepple Imber, City or Mary 20c. Locat	What Co ed St ace - Am Thite, etc.  Why: Will Busines  Cerci ame)  Er Town, St Land	10d. Inside City Limits 1 Yes 2 X No  nuntry?  cates erican Indian, Black,  hite s/Industry  caft  21921
The part of the	Baltin Baltin Biology	in all		Donation 5 Other 321. Sonature of Funeral Service 23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final diseasor condition resulting in death)  Sequentially list conditions,	Specify:  the Licensee  Complications that the on each line.  But a. Hyperten  Due to (or a b.	Cer it caused the death. issive Atherosoliss a consequence of	Do not enter erotic Caro	Name and Ad CKS HO 3 W the mode of o	dress me toc dying, s	of Facility for kton such as ca	Fune Str	erals, eet, f respiratory a	P.A. Elkton,	Mar	yland 21921 Approximate Interval Between Onset and
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  July 27, 2007  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	O. Box 68760, that the death certificate be executed ed by the attending physician and	ched for use as the burial - tra	Physician/Medical	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 l	d.  AMENDE  a the  23c. If ye  1 Liv  Jnknown  9 Ur	ED es, outcome of preg ve birth egnant at time of de nknown	nancy 2	Other (Specif	y) _	Ectopio	c pregna	incy 23e. Dio	Mor	contribut	Day Year e to the cause of death?
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  July 27, 2007  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	Vital Records, P iysician: The law requires the law requires the law requires the lass been signed this certificate has been signed.	2 should be	o Be Completed	examiner?	Hospital: 1			ent 3 DC	PΑ	Other:	Nursir	24a. Wau pe 1 🗹 Ye only one)	as an topsy rformed? s 2 No	24b. Wer prio dea 1 🗸	re autopsy findings available r to completion of cause of th? Yes 2 No
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  July 27, 2007  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	Division of tall or Attending Phers after death.	lled in by the funeral		1 Natural 5 P 2 Accident In 3 Suicide 6 C 4 Homicide	ending evestigation 28e. Could not be etermined (Spe	Place of Injury - At h	nome, farm, st	reet, factory,	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Yes 2 ouilding, e	No etc.	28f. Locatio or Tow	n (Street and n, State)	Number	
30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To the Hospi within 24 hou To the Funer	completely fi		29a. Certifier (Check only one) 2 Medical E	xaminer:On the ba and mani tifier	asis of examination ner stated.	dge, death oc and/or investi	gation, in my	Licens	se numbe	ccurred	d due to the c at the time, d	29d. Dat	e signed	(Month, Day, Year)
PETER AL Date men ownound day a edit in a part in the control of t	9			30. Name and address of per Donna M. Vincenti,	son who completed MD Assista	cause of death (Item nt Medical Exa Registrar's Signa	miner 1		Street	t, Baltim	nore, N	MD 21201			

DHMH 17 Rev 1/2001

OCME ORIGINAL

			For State Registrar	State of Marylan		tificate of		wentai Hy	giene Reg. No.	137	2501/
ç	Physicia	an.	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	/Medic	al	Francis L. Gott			th City Taylor	r Location of Deatl	JLILY	21 2	4007	12 · 12 (W
	Examin	er	4a. Facility Name (If not institution, give s UNION HOSPITAL (		INTY	ELK TOI		П	4c. County		
A.	Funeral	0.00*	5. Social Security Number 6. Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birthpla	ace (State or Foreign
	Director		118-01-9220	M 2□ F 91	Yrs.	Months Days	Hours Min.		1916	Penns	sylvania
	and w		Usual Residence of Decedent  10a, State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
	Maryit f sho ied at	tor	Maryland Ceci	1	E1kton						1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number	<u> </u>	LIKCOII	10f. Zip Code			10g. Citizen of	What Count	ry?
	th with		1592 Augustine He	rman Hwy.		219	921	1	USA		
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Maritar otatas	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13. \	Was Decedent of H f Yes, specity Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	o- 14. Rad Bla	ce - America ck, White, e	
5	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates: WW	II .	I□Yes 2【XNo	Specify:		Specif	y: Whi	te
9500-61212	2 hou atura cal Es	ted	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occup	ation		16b. Kind of B		
212	e. an "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life. L	kind of work done of NOT use retired	during most of woi d)	rking			
	be filed within 72 hours after death with the Marylar death yigiene, and Hygiene, and they filed with them "natural", or items 23a or 28a-f show event, the M-dix al Examiner must be notified at	Co	7		Heavy	Equipmen			1	tructi	ion
yland		Be	17. Father's Name (First, Middle, Last)  George Gott				18. Mother's Nar	Johnson		ne)	
	2 should be and Ments is marked aumatic e	ဥ	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailin	g Address (Street				State, Zip (	Code)
Ma	rtr		Carolyn Blevins/D	*		Mt. Nebo					
ē,			20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	- City or Tov	vn, State
Ĕ	Pages nent of ant: If it ury or o		1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other ( <i>Specify</i> )	emoval from State		emetery		5-2007	Chesape	ake C	ity, MD
Baitimore,	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service License	7 1.	R •	Name and Addre	i Funera.	l Home,	P.A.		
	= # O		23a. Part1. Enter the disease, or comm	for ger	31	8 George	Street,	Chesape	ake Cit		
			shock, or heart failure. List only in	a cause on each line.		er the mode of dyli	ig, such as cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	LUNG CA  Due to (or as a conseq.	NCER						
	Examiner		h	PNELLMONI	_						
		ner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (or as a consag	sence of):						
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	ionoo of):						
Š,	be ex ician burial	al E		Due to (or as a conseq	zence on.						
09/89	tificate be executed g physician and as the burial-transit	edical	d								
XOD			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregna		Testania prognana			23d. Da	ate of deliver	у
	death cer e attendir ed for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		lEctopic pregnancy Other <i>(specify)</i>			Me	onth [	Day Year
r Ö	requires that the een signed by the hould be detache	Physician/N	9 ☐ Unknown  Part II. Other significant conditions con		ultima in the co	adorbing course six	en in Doct I	220 Did	tobooo upo con	tributa ta tin	e cause of death?
S,	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resi	ulung in the u	idenying cause giv	en in Fan I.		Yes 2 No		
Hecords,	v requ	Completed						24a, Was			
ě	e la has	dmo						auto perf	ormed??	death?	sy findings available apletion of cause of
VII.			25. Was case referred to medical				26 Place of Dea	1  Yes ath (Check only		1 ☐ Yes 2	2 No
	Physician: this certific ral director,	To Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	or:		idence 6 □Otl	her (Specify	)
0	ding Ph h. After th funeral		27. Man of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occur	rred	
<u>S</u>	Attending r death. ector: After by the funer	catio	2 Accident investigation 3 Suicide 6 Could not be	00 54 64 44			Yes 2 □ No				
DIVISION	= e = -	Certification:	4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ime, tarm, str y)	eet, factory, office		28t. Location ( City or To	(Street and Numi wn, State)	ber or Hural	Houte Number,
_	pital ours eral filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, deatl	occurred at the ti	me, date and place	e, and due to the	cause(s) and m	anner as str	ated,
	ne Hos n 24 hc ne Fun oletely	Medical	(Check only 2 ☐ Medical Examir one)	ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	opinion, death occ	urred at the time	, date and place	, and due to	the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of cortifle	7		29c. Licens			29d. Date signe		
)			VIMITO	MD		D 6:	3486		JULY,	21,2	00+
(-	+IVA		30, Nam. and Tress of person who co	mpleted cause of death (Item	23a) (Type,	Print)	MID 21	121			

Cto

State Registrar 31. Date filed (Manth, Day, Year) 200

32. Registrar's Signature

DHMH 17 Rev 1/2001

		For State Registrar	State of Mary		rtment of H tificate of L		Re	eg. No.	2 5 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Physici /Medic	al	1. Decedent's Name (First, Middle, Charles  Charles  4a. Facility Name (If not institution, C	. Grimm		4h City Town or	Location of Death	2. Date of Death	Day Yea 23 200	17900
Examin Funeral	er	Manokin Manor Nu	rsing Home	n yrs. last birthday)	Princess If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Somerse	
Director		217-30-1152  Usual Residence of Decedent  10a, State 10b, County	100 M 2□ F	77 Yrs.  Oc. City, Town or Lo		Hours Will.	11-04-1		aryland  10d. Inside City Lim
he Marylan 8a-f show otified at	ector	MD Somers		Princess				0g. Citizen of What	1 X Yes 2 □
ath with ti 23a or 2 ust be n	Funeral Director	30550 Blue Jay			2185			USA	
1215-0036 within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-1 show the Medical Examinar must be notified at	by	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 December 2 □ No If Yes, Give Year or Dates: KO		Was Decedent of Hi fYes, specify Cuba I□Yes 2XX No	ispanic Origin? (Spein, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W Specify:	merican Indian, hite, etc. <b>Thite</b>
21215-0036  d within 72 hours att giene. er then "neturel", or the Medical Exami	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+) none	(Give life. I	lent's Usual Occupa kind of work done o DO NOT use retired	during most of worki	ng	16b. Kind of Busine Telephone	
tnd Z be filed htal Hygi d other event, I	Be	17. Father's Name (First, Middle, La		TCCIII	TCTan	18. Mother's Name	(First, Middle, M	Maiden Surname)	: Сошрану
Maryland of 2 should be file lith and Mental Hy 27 is merked oth treumetic event	2	Joseph Lorence 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	May A11e		, City or Town, Stat	e, Zîp Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important: If item 27 is marked other then "neturel", or frems 23a or 28a-1 show any injury or other treumetic event, the Medical Examinat must be notified at once.		Mary Lou Grimm/  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	☐Removal from State	30550 20b. Place of Dispo cemetery, crer Salisbury	sition (Name of natory or other plac	(e)	Date	s Anne, N	
Physician /Medical Examiner	0	21. Signature of Funeral Service City  23. Part1. Enter the dia a e. or condition of the co	Me I MOO	295 11 e death. Do not ent	673 Somer	eral Home	Prince	es Anne,	MD 21853 Approximate Interval Between Onset and Deat
8760, rate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jusuase of Injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond						
vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certifical reach. sctor: Affer this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at time) 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
cords, P. w requires that been signed b	b	Part II. Other significant condition	s contributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.		,	e to the cause of death Probably 4 Dunkn
Record The law requate has been page 2 should	Completed						24a. Was a autops perform 1 Yes 2	ned2   deat	autopsy findings avail to completion of cause n? res 2 \square
of Vital Re Physicien: The I this certificate ha	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No 27. Manger of Death	Hospital: 1 Inpatient	2 ER/Outpatier		4 Nursing Ho	me 5 Reside	ence 6 Other (5	Specify)
Division of Vital Records,  To the Hospital or Attending Physicien: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be described.	Certification:	1 Natural 5 Pending investiga 3 Suicide 4 Homicide Could no determin	t be OR - Blace of Joine	r - At home, farm, sti	M 1 🗆	k?" Yes 2 □ No		treet and Number o	r Rural Route Number,
e Hospita 24 hours e Funere letely filler	Medical C		Physician: To the best of examiner: On the basis of examiner state	xamination and/or in					
To th within To th compl	Me	29b. Signature and title of certifier	/		29c. Licens	e number	2	9d. Date signed (M July 24	
0+1 EB		30. Name and address of person w		th (Item 23a) (Type,	Print)		BURY, M		

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARGARET B. GODWIN 2007 22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SALISBURY Necomica MEDICAL ENINSULA REGIONAL ENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) 05/17/39 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral VA Country) 1 ☐ M 2 ☐ N Months Days Hours 228-44-8340 68 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director VA Accomack Accomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24204 Church Rd. 23301 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. þ 3 Widowed 4 Divorced 'natural', Completed item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Cook Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental I Howard Allen Margaret Bundick Strand 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Godwin, Sr. 24204 Church Rd., Accomac, VA 23301 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Star East Cemetery 07/28/07 Accomac, 4 Donation 5 Dother (Specify) Signature of Fune 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA Part1. Enter shock, or hear caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. mmediate Cause (Final disease or condition resulting in death) MASSIVE Physician /Medical Due to (or as a consequence of): Examiner 5mall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed this certificate har all director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be Hospital: 1 Phopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:,
completely filled in by the f

D71 5

Registrar

Jimmy lay 31. Date filed (Month, Day, Year) State JUL 2 3 2007

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARROLL St. SALISBURY Md 2180,

1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

### 07-05604 Rot

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

Robert L Green	4	- For State	Sta	ite of Maryl	and / D	eparti Certif	ment of ficate of	Health al	na Menta	ıı mygie		. <b>N</b> o.		1 6.	
	F	egistrar 1. Decedent's Nam	e (First Middle	Last)		Certii	icale or	Death		2. D	ate of Death		Vaar	3. Time of Death	
Physicia Medical Examin	-			ceen						JU	onth ly 21, 20	Day 07	Year	2102 hrs	
(S)		4a. Facility Name (			number)			b. City, Town,	or Location of I	Death		40. 000	nty of Deat		
	Н	Franklin Sq	uare Hospi	tal				Rosedale	ear If Under:	0.41.1=0 0	Date of Birth			rthplace (State or	
Funeral		5. Social Security I		6. Sex	7. Age (In				ays Hours	Min.			Forei	gn ountry) MD	1
Director		213-19-4		1 X <sub>M</sub> 2 F	<u> </u>	35	Yrs				May 10	1, 19	12]	MD	
Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa S	7 4 11	Usual Residence of 10a. State	10b. County		100	c. City, To	own or Locat	ion						10d. Inside City L	- 1
<b>*</b> "		MD	Baltin	nore	l E	Essex	ĸ				1141			1 Yes 2 X	No
arylan 8a-f s	Director	10e. Street and No						10f. Zip Code				_	of What Co	untry?	
the M a or 2	ij	332 Sass	safras I	Road				21221				JSA	Dans Ami	erican Indian, Black,	
after death with the Maryland ral", or items 23a or 28a-f show iner must be notified at once.	eral	11. Marital Status	ried 2 🗓 Ma		ecedent Eve Forces?	er in U.S.	. 13. Wa	s Decedent of es, specify Cub	Hispanic Origii ban, Mexican, I	n? ( Specify Puerto Rica	y Yes or No- an, etc.)		White, etc.	erican indian, black,	
r death or ite	Funeral			orced If Yes, Give	2 X	No	1	Yes 2 X	No specify:			Spe	cify: Wh:	ite	Í
5-0036 led within 72 hours afte dygiene. other than "natural", the Medical Examiner	ρ	3 Widowed		or Dates: cify only highest g		eted) 1	16a. Deceder	nt's Usual Occu	pation (Give ki	ind of work	done	16b. Kind	of Business	s/Industry	
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5-0 iled w Hygie Jothe		17, Father's Name	e (First, Middle,	Last)							yn. Mye		102)		
2121; uldibe fill Mental F marked	Be	Ian Gree	en Name/Relations	hin (Type, Print)		-	19b. Mailin	ng Address (S	treet and Num	ber or Rura	Route Nun	ber, City o	r Town, Sta	ate, Zip Code)	-
⊙ ¬ ∞ :=	2	Ruth E.					1500	Chesape	ake Ro	ad Mi	ddle I	River	. MD	21220	
nore, MD ages I and 2 sh ent of Health an nt: If item 27 i	1	20a. Method of D	isposition				lace of Dispo rematory or o	sition (Name of	cemetery,	D	ate	20c. Loca	ation - City	or Town, State	
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Baltimo permit. Page Department of Important: injury or ott		21. Signature of f	Funeral Service	Licens#e/			22. GO	Name and Add	ress of Facility	ation	Serv	ice 1	P.O.	Box 784	
ii ji Den 📆	72 - 20	1 Jewes	4 & He	tte	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MO1	251 Be	verly I	Heck	rotte	D A	est shock	-ksvi	11 = MP at Between Ons	1021
Physician		23a. Part I. Enter failure. List	the disease, of only one cause	e on each line.				the mode or dy	111g, 30011 43 or	214100 01 10	) 			Between Ons Death	et and
\ dical aminer		Immediate Cause or condition resu	e (Final disease	a. Narco	tic int as a consequ						_			-	
J	1			b.	as a consequ	acrico or,	<i>/-</i>								
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uted nd ransit	Ĭ	events resulting	in death) Last	d											
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760, cate be physici	Ĭ,	IF FEMALE: 23b. Was decede	ent pregnant in	Ale o	es, outcome	e of pregr		Fetal death	3 Ectopi	c pregnanc	ry		Date of deli Ionth		ear
O. Box 6876 that the death certificate ned by the attending phy denothed for use as the t	Physician/M	past 12 mon			ive birth regnant at ti	me of de		Other (Specify)	-						
Sion of Vital Records, P.O. Box Attending Physician: The law requires that the death releast.  From the street of	ysic	1 Yes 2	No 9 U		Inknown				i= D		23e Did	tobacco us	e contribut	e to the cause of dea	ath?
P.O.   es that the gned by t	by P		gnificant cond	itions contribut	ing to death	but not re	esulting in th	e underlying ca	use given in P	art i.					known
S, P.C.	>										24a. Wa		1 24b. Wer	e autopsy findings a	available
Li (Li E)  Vital Records,  sysician: The law require this certificate has been si  this certificate has been si  this certificate control I	Completed											opsy formed?	deat		
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Nic		1 Yes 27. Manner of D	2 No		Inpatien Date of Injur		ER/Outpation		c. Injury at Wor		8d. Describ				
n of ding Pl		1 Natural		(	Month, Day, Ye 1 7/21/2	ear)	ł	:19 pm	Yes 2 X	Tale I	unk				
Sion Atten	oy une	2 Accider	nt Inv	estigation 28e				treet, factory, o	ffice building,	etc. 2			d Number o	or Rural Route Numb	ber, City
Division  Division  al or Attendi	Certification:	3 Suicide	de de	termined (Sp	ecify) hot	use				3		afras		sex.MD	
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# # # # # # # # # # # # # # # # # # #	Medical	one) 2	✓ Medical E	xaminer: On the b and mar	asis of exam ner stated.	nination a	and/or invest	igation, in my o	pinion, death c	occurred at	the time, da	te and plac	, and ddo	(Month, Day, Year)	
F 3 F	ಠ   ಕ	29b. Signature	and title of cert	ifier					License numbe O.C.M.E.	er .		ì	22, 2007		
		llour	we VI	nelland	U_							30.9			
				on who complete	d cause of do Medical	eath (Iter	m 23a) ner 111	l Penn Stre	et, Baltimo	re, MD 2	1201				
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Pos	Stat sietra		JUL 2	5 2007	JEING JOB	Killing .	of the same	A STATE OF							

Registrar

			1 - For Stata Registrar	State of Ma	_	-	artment of H tificate of I		Men		ene		7) !:	0.0
	Observatori		1. Decedent's Name (First, Middle, L.	ast)						Date of Death	Day	Year	3. Time of	Death
	Physici /Medic		Enrique M. Gut	tierrez							, 2007		9:55	a <sup>M</sup>
F.	Examin	er	4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or	Location of Deat	th		4c. Count	y of Death	1	
	Funeral Director		Holy Cross Hosp 5. Social Security Number 6.	oital Sex 7. Age 1₽M 2□F	(In yrs. last bin	thday) Yrs.	Silver If Under 1 Year Months Days	Spring If Under 24 Hrs Hours Min.	. 7	Date of Birth Month, Day,	Year)	gome 9. Birth Con Boli	place (State ountry)	or Foreign
	pu »		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	antion						10d. Inside C	its Limite
	Aaryle Pool	ō												2 XNo
	28a-	Director	Maryland Montgo	duery	Б	etn	esda 101. Zip Code			10	g. Citizen of	What Cor	untry?	
	death with the Marylend me 23a or 28a-f ehow must be notified at		7604 Leesburg I	Orive			20817	7		}	_	livi		
0000	permit. Peges 1 and 2 should be ilied within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or iteme 23s or 28s-f show any figury or other traumatic event, the Madical Examinat must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba X Yes 2 No	ispanic Origin? (S in, Mexican, Puer Specify:Bo1:			Bla	ce - Amer ick, White White		
7-0-7	lhin 72 ho e. en "netur Medical	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed) College (1-4or 5		Deced (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wo	orking	1	6b. Kind of E	Business/I	ndustry	
7	ed wit ygien yer th	Con		5+		De	ntal Sur	,					urgery	
and	be fit d off	Be	17. Father's Name (First, Middle, Las Enrique Gutierre					18. Mother's Nar				me)		
2	hould d Mer marke matic	2	19a. Informant's Name/Relationship			Mailin	g Address (Street a	Edith A				Ctata 7	in Cadal	
2	nd 2 s lith an 27 is r		Wilma Gutierrez				4 Leesbur							7
more,	Peges 1 arent of Hea		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Speci		cemeter	y, cren	sition (Name of natory or other plac tan Crema		,	2,	0c. Location			
parillinor	permit. Depertm Importa any inju		21. Signature of Funeral Service Lice	•-		22 F	Name and Address rancis J. 00 Univer	ss of Facility COILINS	s Fu	ineral	Home	Inc.	Virgin ng, MD	(E-9)
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	niplications that caused	the death. Do r								Approximat Interval Bet	0
À	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Septic S		of):							Onset and	Death
		Jer	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying	b. Sepsis Due to (or as a	a consequence	of):								
	ificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	<sub>c.</sub> Pneumoni										
Š	e exe	Ex	resulting in death) Last	Due to (or as a	a consequence of	of):								
00/00	cate b	edical		d								-		
O. DOX 0	The law requires thet the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. tf yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					ate of deli-		Year
T.	s thet ned b e deta	y Pt	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the un	nderlying cause give	en in Part I.		23e. Did tob	acco use con	tnbute to	the cause of c	leath?
coras,	quire an sig uld b	ed b	Anoxic Encephalo	pathy, Res	pirator	y Fa	ailure,			1 🗆 Yes	s 2 <sup>™</sup> No	3 🗆 Pro	bably 4 🗍	Jnknown
ושבני	The law re ste hes ber bage 2 sho	ompiet	Cardiac Arrest							24a. Was an autopsy perform 11 Yes 2	ed?	prior to o death?	opsy findings ompletion of d	available ause of
150	clen: ertific ector,	Be (	25. Was case referred to medical examiner?					26. Place of Dea						
5	Physi this c	5	1 Yes 2 No		nt 2 ER/Ou			4 🗆 Nui Sing r					ify)	
NISIOI	ending I sath. or: After he funer	ation	27. Manner of Death  12 Naturat 5 Pending 2 Accident investigation		Year) 280. I	rime of njury	28c. Injun Work	γ aτ (? Yes 2 □ No	280.	Describe nov	w injury occu	rrea		
Š	rs efter de ei Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	building, etc	:. (Specify)					City or Town,	State)		ral Route Num	ber,
	To the Hospital or Attending Physicien: The law within 24 bours effected beach. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	edicai	one)	hysicien: To the best of minar: On the basis of and manner sta	examination and	death dor inv	estigation, in my of	oinion, death occu	e, and o urred at	the time, da	te and place,	and due	to the cause(s	5)
	To corr	Σ	29b. Signature and title of certifier	- MA	$\mathcal{O}$		29c. License			29	d. Date signe	·		
	8			/		_	D633	43			Ju:	ly 19	2007	
			30. Name and address person who Irina Ruban, MD	1500 For	est Gle	n Ro	oad, Silv	er Sprin	ıg,	MD 209	910			
i	Sta Registr		31. Date filed (Month, Day, Year)  JUE 23 2	32 Aegistra	r's Signature	Pol	ME	, ,						

			For State Registrar	State of Ma	-	•	nt of Health a e of Death	ind Mer	ntal Hygie		7 2	5082
	Physici	an	1. Decedent's Name (First, Middle, Last)		ann				Date of Death Month	Day Yea		Time of Death
*	/Medic Examin		4a. Facility Name (If not institution, give		Stare	4b. City	Town, or Location o			4c. County of D	eath	d
	Funeral Director		5. Social Security Number 6. Sec	7. Ago	o (In yrs. last birth 80 <sup>Y</sup>	Months	Days Hours	Min.	Date of Birth (Month, Day, Yes	9. 1927	Birthplace Country) PA	(State or Foreign
	anyland show	5.	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						nside City Limits
	vith the M	Director	MD Washingt  10e. Street and Number	on	Hancoc		o Code		10g.	Citizen of What		A
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural; or items 23e or 28e-f show other traumatic event, the Medical Exemples must be inclined at	by Funerai	12 Pennsylvania  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Norocced	Avenue  12. Was Decedent I Armed Forces?  1 Tyes 2XIII If Yes, Give Year or Dates:		13. Was Dece	21750 dent of Hispanic Origicity Cuban, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race - A Black, W	/hite, etc.	ndian,
Maryland 21215-0036	d within 72 hou piene. r then "natura the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation	+)	Decedent's Usu (Give kind of w life. DO NOT I	ork done during most	t of working	1 5	o. Kind of Busine	ess/Industr	у
/land	should be filed and Mental Hyge marked othe amatic event,	To Be C	17. Father's Name (First, Middle, Last)  Orville G. Leade	er					First, Middle, Mai Wertz	den Sumame)		
	1 and 2 sho Health and 1 em 27 Is ma		19a. Informant's Name/Relationship (Ty Margaret E. Pryor/			•	s (Street and Numbe Berry Road				te, Zip Cod	(6)
Baltimore,	permit. Pages 1 a Dep riment of He Important: If item any injury or oth once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)			Disposition (Na r, crematory or Lawn Met		Date 07/31/		e. Location - City Serstown		State
Balt	permit. Dep rtr Imports any inju		21. Signature of Funeral Service Licens		١		nd Address of Facility Funeral Ho	. 1	41 West A. Hanco			-0368
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	the death. Do note.	ot enter the mo	de of dying, such as			4	App	proximate erval Between set and Death
8760,	death certificate be executed e attending physician and idea to use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. COVO Due to (or as		9V:	ters i	dis	₹55 C		5	your
O. Box 6	res that the death certific igned by the attending p be detached for use as i	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3⊟Ectopic p				23d. Date of Month	delivery Day	Year
rds, P.	requires that the een signed by th hould be detache	ed by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	the underlying	cause given in Part I.			co use contribut	te to the ca	1
Division of Vital Record	The law ete has b page 2 sl	Completed							24a. Was an autopsy performer	d?   deat	e autopsy f to comple h? Yes 2	findings available tion of cause of
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			000		Check only one)			
ion of	Attending Physic death. sctor: After this by the funeral di	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28b. T		OA 4 Nu 28c. Injury at Work? 1 Yes 2	280	5 Residence d. Describe how		Specify)	
Divis	F 8 F 5	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, far c. (Specify)	m, street, facto	ry, office	28f	Location (Stree City or Town, S		r Rural Ro	ute Number,
	To the Hospitel or within 24 hours aft To the Funerel Discompletely filled in	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	rsician: To the best iner: On the basis o and manner st	examination and	death occurre	d at the time, date an n, in my opinion, dea	d place, and th occurred	d due to the caus at the time, date	se(s) and manne and place, and	or as stated due to the	d. cause(s)
	To T To I	Σ	29b. Signature and title of certifier	110		1	C. License number	7		Date signed (M		
,			30. Name and address of person who co		eath (Item 23a) (	Type, Print)	194161 Kidse	-		16170	1	700 7
	le		Cary Kazlac M. 31. Date Tiled (Month, Day, Year)		ar's Signature	400	Ridge	Rel	Colum	ns ic M	10/2	1044
	Sta Registi		ALIG 0 6 200	55	a. 3 Orginature	peste						

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Ollie 2007 6:25 AM Ju /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number MATY AND Nedical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 😿 F 67 221-26-1057 DELAWARE Director 8-14-1939 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at SUSSEX SELBYVILLE **DELAWARE** 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 UNITED STATES 37260 HUDSON ROAD Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant; if fem 27 is marked other than "natural", or Items 23 ury or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Completed by WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OLLIE BAKER FRANCES RICKARDS မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARRELL W. HITCHENS / SPOUSE 37260 HUDSON ROAD, SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages ' Department of the important; if ite any injury or of once. 1 ☑ Borial 2 ☐ Cranation 3 ☐ Removal from State BISHOPVILLE CEMETERY 7-24-2007 4 Donation 5 □ Other (Specify) BISHOPVILLE, MARYLAND 21. Sunature Fun Jul 9 MELSON FUNERAL SERVICES, LTD. THATCHER STREET, FRANKFORD, DE 19945 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dise shock, or heart failu Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DISSEMINATED INTERVASCULAR Corculation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) P.O. ed by the a detached i 2 X No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ver autopsy page Breterenia 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Math 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury (Month, Day Year) 5 Pending М 1 ☐ Yes 2 ☐ No investigation the 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 Homicide

MA 20

within 2

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ELIC COX MD

Medical

South 5+. Greene 32. Registrar's Signature

and manner stated.

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DHMH 17 Rev 1/2001

🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1598967499

MO

BAILIMORE

29d. Date signed (Month, Day, Year)

21201

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 10:36A /Medical 100 O 7 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Trauma UMMC Shock PNter Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country)
 New York 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ▼ M 2 □ F Director 113-78-3262 16 Feb. 2, 1991 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 📉 No Director Union Bridge Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be not or other traumatic event, the Medical Examiner must be not or other traumatic event. 306 Bucher John Rd. 21791 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 student high school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeffrey D. Hook Susan Wittig ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Bucher John Rd. Union Bridge, MD 21791 Jeffrey D. Hook/ father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 7/28/2007 | nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Significe of Funeral Service Licen X atharise Ε. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MUVI /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed NEDICAL EXAMINER Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnatic 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 ENo or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 2 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural lotre...-... within 24 hours after deau.. To the Funeral Director: Aft 1 ☐ Yes 2 ☑ No 11107 Z100 MVC 2 PAccident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined tmill Ed. Taneytoun, ND 21787 the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shea 7,0022 St. Bathmore 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 6 2007

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <del>25</del> 2007 12:30 p <sup>M</sup> Owen James Harris July /Medical Ctr 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Lutheran Village Health Care Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 30 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 215-03-4332 88 Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or iteme 23a or 28a-f ehov other traumatic event, the Mudical Examinar must be notified at 1 AYes 2 No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 239 St. Mark Way 21158 USA Pages 1 and 2 should be tiled within 72 hours after deeth nent of Health and Mental Hygiene. If Item 27 ie marked other than "natural", or Iteme 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 120 Yes 2 □ No WWI. If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 General Electric Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estella Welsh Owen Joseph Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Michael Buttner/Friend 1904 Carter Mill Way Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place PK 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Depertment of Important: If it any injury or o \*DBurial 2 Cremation 3 Removal from State Meadowridge Memorial | 7/25/2007 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts funeral Home and Chapel, P.A. Show K 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary **Physician** Hypertension disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed 1001 Hu that initiated events resulting in death) Last ng physiclen ar Due to (or as a consequence of Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 1 ☐ Yes 2 No 41004 17/21 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 1 Yes 2 No Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٢ 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident ector: 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide ā 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) afanswark mo 7/23/0 51705 1,10 DOTIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kertminster PANSURIYA modwim DR 31. Date filed (Month, Day, Year) . Registrar's Signature State JUL 2 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month July 23, 2007 **Physician** 11:45 AM Charles Ernest Horn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 29, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1X M 2□ F New York 51 074-50-3237 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Elkridge MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21075 6636 Washington Blvd. #11 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? 1 Armed Parkers 2 No If Yes, Give 1 Q 7 7 → 0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 💥 No Baltimore, Maryland 21215-0036 Specify: White rres, Give Year or Dates:1977-01 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Hospital Patient Client Driver permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygid Important; If Item 27 Is marked other of any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Kramer William Ernest Horn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6636 Washington Blvd. #11 Elkridge, MD 21075 Mista Horn/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 07/24/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility action Service P.O. Box 784 21. Signature of Funeral Service Licensee Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) conce UNknown Montres **Physician** MITALIANC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the a detached t 9 Unknown 9 \ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onli one director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO3 PW 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After t Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral properties. death. 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and Afte of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAMIES 6701 N. in

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State

Registrar

31. Date filed (Month, Day, Year)

32. P gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are L Amend 28b per dr., 88/1,09/18/0/dhb State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI line a-b, 25,27a,b,d&f per/MF 88/1/0/DTI Registrar Certificate of Death Ensure All Copies Are Legible. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ам 23 9:07 July 2007 Margo Ann Holloway /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🗓 F Yrs. Director 60 April 27, 1947 <u>Pennsylvania</u> 192-38-1956 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If Itsm 27 Is marked other then "natural", or items 23e or 28e-f show ury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 14401 Lewis Colony. Bdg A, Apt. 365 21842 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) laborer Beauty Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ David A. Nagel Katherine E. Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12432 Balston Road, Philadelphia, PA 19154 Katherine Nagel/ mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
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sny injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/24/2007 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Signature of Funeral Service Licensee JOLLEY MEMORIAL CHAPEL, P.A. 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Hip Fracture /Medical Due to (of a a consequency f): Porting with de Examiner Sequentially list conditions, it any, reducing to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) physicien s the burial Box 68760, por enomina Physician/Medical Mr. Ca attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No been signed by the should be detached o 9□ Unknown 9 Unknown Δ. Part A Differ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital or Attending Physician: Marge 38-1 director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) To Be Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 ER/Outpatient 3 DOA 2/2 this Director: After that in by the funeral 28a. Date of Injury (Month, Day 28d. Describe how injury occurred subject fell 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification: Month, (lay year)

288. Plate 27 h 20 VAt home, farm, 1 Natural 5 Pending investigation 1 ☐ Yes 2 No death. 2 Accident 3 Suicide 4 Homicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, #365 City or Town, State) 14401 Tunnel Ave. #365 28f street, factory, office To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by yd ui bellij determined building, etc. (Specify) Ocean City, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type Print) Name and address of person 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar 24 2007

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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Meonse.		21. Signature of Funeral Service Lice		111	22	. Name and	Addres	s of Faci	lity					
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Re	he lay ge 2	E D									i au	topsy rformed?	,	prior to d d <u>ea</u> th?	completion of cause of
or Vital Records,			25. Was case referred to medical						OC Disc	o of Dooth	1 Yes		No	1 🗌 Yes	2 No
5	s cert	o Be	examiner?	Hospital:	ent 2 🗆 i	ER/Outpatien	t 317 DO4	Othe	r.		n <i>(Check onl</i> ) me 5 ☐ Re		6 DO#	or (Spa	26.4
ō	Attending Physician: r death. ector: After this certifica by the funeral director, I	<u>ان</u>	27. Manner of Death	28a. Date of Inju		28b. Time of		c. Injury Work			28d. Describ				siy)
on	nding F th. :: After e funera	tior	1 Accident 5 Pending 2 Accident investigation		y Year)	Injury	М		:? ∕es 2 [	No					
Division	I or Attendater death Director:	Certification:	3 Suicide 6 Could not 4 Homicide determined	Zoe. Flace Of III	jury - At hor tc. (Specify	me, farm, str	eet, factory,	office			28f. Location City or 7			er or Ru	ral Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce													
	the I hin 24 the F	ledi	one)	and manner st											
	vitl To	Σ	29b. Signature and title of certifier						number 5703				Date signe $_{ m 1}1{ m y}~1$		h, Day, Year) 2007
7	In		Peru					UUJ.	,, 03			"	y 1	J, 2	
i	12		30. Name an odress of person who Tsion BerHane,	completed cause of 0	death (Item	23a) (Type,	Print) Or. Ch	eve	rly.	Md.	20785	5			
/11	/ /	i i	TOTOU DETUGUES		P				, ,						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2 3 2007

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items
State of Maryland / Department of Health and Mental Hygiene, 23a, 25 per me, g870, 08/02/07/ehb 2. Date of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death **Physician** June 2007 Bernice Alma Jenkins 2150 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Montgomery Silver Spring, Maryland Holy Cross Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Min 1 □ M 2**X**1 F 579-72-2020 55 July31,1951 Director Washington, D C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f show notified at 1 TX Yes 2 □ No Director Prince Georges Capitol Heights, Maryland MD 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number r than "natural", or items 23a or the Medical Examiner must be 6626 Ronald Road #202 20743 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WSSC Data Entry Clerk 11thmarked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Jenkins Lena Robertson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharrone Russell ( Daughter) 4031 Postgate Terrace #302 Silver Spring Md 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 4 Donation 5 ☐ Other (Specify) Gates of Heaven Cemetery 6/22/07 | Silver Spring, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee Terry A Austin 3821 14th Street N W Washington, D C 20011 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Complications of Thyroid Goiter with Immediate Cause (Final Anoxic Brain Injury Tracheal Compression **Physician** disease or condition /Medical Due to (or as a consequence of) Examiner Asystalic Cardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Rěćords, þ Thyroid Surgery 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes 24a. Was an certificate has autopsy perform Congestive Heart Failure Division or Vital Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attendi nours after death. neral Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital c To the Funeral 💆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. To the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and j D64174 06/13/2007 30. Name and add ho completed cause of death (Item 23a) (Type, Print) s of pe rson

State Registrar Jogi 🗸

AUG 0 2 2007

31. Date filed (Month, Day, Year)

Vikas

DHMH 17 Rev 1/2001

**ORIGINAL** 

Registrar's Signature

1500 Forest Glen Road, Silver Spring, Maryland 20910

			For State Registrar	State of Marylan			ite of D		_	Reg. No.	. 0 0 7	1.00	2 9
	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Do	
	/Medic	al	4a. Facility Name (If not institution, give si	Helen S. Ke	eay	4h Cit	v Town orto	ocation of Death	July_	28	2007 county of Death		A M
	Examin	er	23 Rose Court	(reet and number)			lkton	DOMESTIC TO LINE OF LINE			Cecil		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		er 1 Year   I	f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birth	place (State or F	oreign
	Director		000-26-1343	<sup>M</sup> <sup>2</sup> <b>X</b> <sup>F</sup> 93	Duys	7,0010	JAN 10	, 191	4 Mai	né			
	tand		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10d. Inside City	Limits
	Mary a-f eh	tor	Maryland Cecil	F	1kton							1 Tes 2	No No
	or 284	Directo	10e. Street and Number			10f. Z	ip Code			10g. Citize	en of What Cou	ntry?	
	ath w	ral	23 Rose Court		6 40		21921		was Name Na		ited St		
	item item	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No				Mexican, Puerto	pecify Yes or No Rican, etc.)	.   '	Black, White		
036	el', or	by I	3 ₩ Widowed 4 □ Divorced	If Yes, Give X Year or Dates:		1 🗆 Yes	2 X No	Specity:		S	Specify: Wh:	ite	
2-0	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade		(Give	kind of v	sual Occupation	on ring most of worl	king	16b. Kind	d of Business/Ir	ndustry	
121	within 72 hours after death with the Maryland ene. then "naturel; or iteme 23s or 28s-f ehow the Madisal Examiner must be notified at	Completed	Elementary/Secondary (0-12)	2 College (1-4or 5+)		ner Iner	use retired)			Nu	rsing H	lome	
<b>Q</b>	Hygi other	Be Co	17. Father's Name (First, Middle, Last)	<del>-</del>			11	8. Mother's Nam	ne (First, Middle				
/lan	uld be Vienta Irked Itic ev	To B	Archie Sanderson					Bertha	Berwick				
altimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at	1	19a. Informant's Name/Relationship (Typ		1	-			ral Route Numb			p Code)	
e,	1 and Health em 27 ther t		Elisabeth K. Flyn 20a. Method of Disposition		23 KC Place of Dispo cemetery, crei			-	Maryla		.921 ation - City or T	own, State	
Jon	permit. Pages 1 Department of H importent: If ite eny injury or ot		1 🕅 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	anioval nom State	cemetery, crei • Four			Augus 2007	st 3,		ion, Ma		
alti	mit. F partme sorter / injur		21. Signal re of Funeral Service License	е	_ 22	2. Name	and Address	of Facility	1 - D				
m —	Depa Impo eny ir	UN	Donud S.	Huko	10	icks )3 W	Home 1 Stock	cton Str	rals, P eet, El	.A. kton,	Mary 1a	and 2192	21
			23a. Part1. Enter the disease, or complik shock, or heart failure. List only on	cations that caused the deal e cause on each line.	th. Do not en	ter the m	ode of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Betwee Onset and De	en eath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CONGEST	iVE	H	ent	FAILU	SP				
	Examiner			CONGEST  Due to (or as a consect  Crifical	tuence on:	NA	S+1	o no si	C				
		ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a consec	uence of):	,	, ,	3 1	J				
Sh	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Oue to (or as a consec	was of:								
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	ifficate g physas the	edical	~ 0	•									
Вох	death certifii e attending p od for use as	an/M	23b. was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		]Ectopic	pregnancy			23	3d. Date of deliving	very Day Ye	25
	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of o	death 50	Other	specify)				WOTH	Day 16	a.i
P.O.	res thet the de signed by the a be detached f		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	inderlying	g cause given	in Part I.	23e. Did	obacco us	e contribute to	the cause of dea	ath?
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900	e law requires thet the hes been signed by th ge 2 should be detache	Completed	Chronic Atiac	FibrillATI	SN				24a. Was		24b. Were aut	opsy findings av	railable
Œ.	The ete h page	Сош							perfo 1 ☐ Yes	Pried? 2 No	death? 1 ☐ Yes		
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Other		th (Check only				
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ion	nding ath. r: Afte e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		s 2 No					
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, lact	ory, office		281. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Numbe	∋ <i>Γ</i> ,
Ω	urs af urs af erel D		29a. Certifier 1 Certifying Phys			4-							
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical		sician: To the best of my known. Inter: On the basis of examination and manner stated.									
	To th within To th comp	Me	29b. Signature and title of certifier			1	9c. License r	number		29d. Date	signed (Month	, Day, Year)	
)			+ Hy Non	ell Nos			D 3	351	0	Jul	31.	2007	
	2	-	30. Name and addr ss of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	3)	Panal	o Pu	,	40, ,	t Do	1974)
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	J10	, 00	1- 01/6	5 r G	/	- Will	- /- /	1/02
	Registr		Alic 0 2 200	1 6	20 2	- 67							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** KENNEY NSI ule 2007 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL Examiner SHTER ALISBURY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**™**M 2□F 221-26-960 Delaware Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f shov must be notified at Mardela 1 ☐ Yes 2 No WICOMICO Director 10g. Citizen of What Country? 10e. Street and Number San Domingo United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc. rai", or item Examiner r 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Baltimore, Maryland 21215-003 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat way injury or other traumatic event, the Medica ene. (Give kind of work done during most of working life. DO NOT use retired) FARMING-Elementary/Secondary (0-12) College (1-4or 5+) FARMER INdustries 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KENNEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurel, DE 1995 Le 20c. Location - City or Town, State Samuel Gaines 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 24/07 Colombia, Delaware 917 W. Isabella Street Mt. Nebo UMC Cem. of Signature I Funeral Se FUNEIGL Home Salisbury, maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Arterioscleratio Cardiovarcalar disza/e **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed y physician and ss the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as attending nse IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 힏 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Certification: 1 Alaturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 124. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7-20-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E Carroll Street Salishum, MD 21901 ag 100 31. Date filed (Month gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

07-05496 Fred Kiviat

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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1		3			0		and .	

	1- For State Registrar	Certifica	te of Death		Reg. No.		1 6300
Physician/	Decedent's Name (First, Middle,Last)			Lм	ate of Death onth Day	Year	3. Time of Death 1853 hrs
edical Examiner	Fred E.	Kiviat		Ju	ly 17, 2007	. County of Death	1000 1115
	4a. Facility Name (if not institution, give stree 4084 Union Church Road	t and number)	4b. City, Town, or Lo Salisbury		V	Vicomico	
Funeral	Social Security Number     6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24Hrs. 8. Hours Min.	Date of Birth(MM/	DD/YYYY) 9. Birt Foreig	hplace (State or
Director	059 <b>–</b> 32–5480 1 Хм	<sub>2</sub> 67	Yrs.	Tiodis IVIIII.	05/16/194	40 Co	New York
manifered and production of the particles	Usual Residence of Decedent	10c. City, Town o	or Location				10d. Inside City Limits
d thow any	10a. State 10b. County  Maryland Wicomico			2	1 Yes 2 X No		
he Maryland t or 28a-f show iffed at once. Director	10e. Street and Number	Salish	10f. Zip Code		10g. Citi	zen of What Coul	ntry?
th the Maryland 23a or 28a-f sho notified at once.	30047 Deer Harbour	Drive	21804	6.70	T T	JSA	
h with beno		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispa If Yes, specify Cuban,	anic Origin? (Specify Mexican, Puerto Rica		<ol><li>Race - Ameri White, etc.</li></ol>	can Indian, Black,
or ite	Never Married 2 & Married 1	Yes 2 X No	1 Yes 2 X No	ong gift (		Specify:	white
s after	3 Widowed 4 Divorced If Yes or D:  15. Decedent's Education (Specify only high	hest grade completed) 16a [	Decedent's Usual Occupation	n (Give kind of work	done 16b.	Kind of Business/	-1
0036 within 72 hours a giene. her than "natura Medical Exami	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. I	OO NOT use retired)			
thin 72 than than than than than than ordical	12 8	C	Chemist			Chemical	1
5-0( led wi Hygier other Ihe M	17. Tauler's Ivalie (1113t, Widdle, Edet)		11	8.Mother's Name (Fir			
D 21215-0036 should be filted within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		7-1-4	o. Mailing Address (Street	Judith	Glicks	man City or Town, State	e, Zip Code)
D 21 should and Me 7 is ma	19a. Informant's Name/Relationship (Type, Janice A. Kiviat/w	· ·	30047 Deer Ha				
ore, MD 2121 se I and 2 should be fi of Health and Mental If iten 27 is marked her traumadic event,	20a. Method of Disposition	20b. Place of	of Disposition (Name of cem		ate 20c.	Location - City or	Town, State
OFF ges 1 it of H i: If i	1 Burial 2 XCremation 3 R	emoval from State	ory or other place) sbury Cremato	ry 7/23	/07	Salisbur	v, MD
Baltimore, Permit. Pages La Department of He Important: If ite injury or other t	4 Donation 5 Other Specify: 21. Signature of June pai Service Licensee						Association
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is una injury or other traumatic ev	1/1/ Kbller	2 CFSP	1 501 Snow H	ill Rd.	Salisbur	v, MD 21	804
Physician	Z3a. Part I. Enter the disease, or complication failure. List only one cause on each line	ons that caused the death. Do no	ot enter the mode of dying, s	such as cardiac or res	spiratory arrest, sh	nock, or heart	Approximate Interval Between Onset and Death
'Medical aminer	Immediate Cause (Final disease a. Mul	tiple Injuries					Deatif
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ģ	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence of):					
ted nisit	(Disease or injury that initiated	to (or as a consequence of):					
ansit							
'60, rate be executed physician and he burial - transit	UNPENDED	MENDED					
760, cate be ex physician he burial	IF FEMALE: 2	3c. If yes, outcome of pregnancy		T-ta-is -respons		3d. Date of delive Month	ry Day Year
Sox 687 leath certific e attending	23b. Was decedent pregnant in the past 12 months?	The second second	Fetal death 3 5 Other (Specify)	Ectopic pregnancy		WOTH	Day 10a.
). Box 683 the death certiff by the attending ched for use as	1 Yes 2 No 9 Unknown g		J Other (Speedily)				
that the done of the dotached		tributing to death but not resulting	ng in the underlying cause g	iven in Part I.			o the cause of death?
, P.C						A STATE OF THE PARTY OF THE PAR	autopsy findings available
Records,   The law requires freate has been sign, page 2 should be		<u> </u>			24a. Was an autopsy performed	prior to	completion of cause of
ecc he lav ate ha					1 ✓ Yes 2		
al R	25. Was case referred to medical			of Death (Check onl		- []	
F Vita Physicia or this ce	1 Yes 2 No	Illpatient 2 2100	Surpation o Bon	Other Nursing H	Home 5 Resi	dence 6 V Oth	er: Scene
Division of Vital Records, P.O. spital or attending Physician: The law requires that towns after death. Fread Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac	27. Manner of Death  1 Natural 5 Pending	(Month Day Year)	' '   '		edestrian stru		
Siol Atten r deatl ector: by the	2 Accident Investigation	28e. Place of Injury - At home,	farm, street, factory, office b	ouilding, etc. 28	3f. Location (Stree	t and Number or i	Rural Route Number, City
Divi	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	(Specify) Major Road / H		40	or Town, State) 84 Union Churc	h Road, Salisb	ury, Md.
		To the best of my knowledge, do the basis of examination and/or	eath occurred at the time, do	ate and place, and du	ue to the cause(s)	and manner as st	ated. the cause(s)
To the Hos within 24 h	an an	manner stated.	29c. Licens			d. Date signed (A	
60	29b. Signature and title of certifier	2	O.C.			uly 18, 2007	
NA.	Carolis	ploted and of death (from 22a)					
20	30. Name and address of person who com Laron Locke MD. Assistan	t Medical Examiner 1	) 11 Penn Street, Baltir	more, MD 2120	1		
Sta			*				
Registr	JUL 2 4 200	7 Ellerane M.	Samuelle 1				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 25002 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 17, D2007 Year **Physician** James Marshall Keaton 10:19 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster 5. Social Security Number (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 10, Director Pipestem, W 235-48-1457 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 27s ----- any injury or other traumatic event. The Maryland once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Finksburg Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 21048 10g. Citizen of What Country? 1019 Ridge Rd. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: 1952 þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry
J.W.& M. Building (Give kind of work done during most of working life. DO NOT use retired) Elementary/\$600ndary (0-12) College (1-4or 5+) General Contractor Contractors 18. Mother's Name (First, Middle, Maiden Surname)
Lula Ardie Hopkins 17. Father's Name (First, Middle, Last)
William Bulas Keaton ပ <sup>19a</sup> Informant's Name/Relationship (*Type. Print*) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1019 Ridge Rd., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem. Gardens 7/21/2007 Finksburg, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 Approximate Interval Between Onset and Death art1. Anter the disease, or complications that the cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PHEROSCIEVOTIC Cardiovasculor Diséase Immediate Cause (Final disease or condition resulting in death) **Physician** OYV /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Man of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation death. s after death.

It Director: A

d in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af
To the Funeral D
completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number WJL STIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 M

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State AMEND#17618, perFH, 7/24/07, DFS, Moco Registrar AMEND#290perMD7/23/07, BW, Moco Certificate of Death 10 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2:00 PM 13, 2007 Ju<sub>1</sub>v Lillian Kieselstein /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year)
Feb. 11, 1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 21 F New York 115-01-7033 92 1915 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 tx Yes 2 □ No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 9 Sprinklewood Court Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hairstylist Beauty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked oth <del>Lillian Bass</del> Anna Taxman Monnis Bass **Kieselstein** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Carol Rose Flaum / Daughter Sprinklewood Court, Potomac, Maryland 20854 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 7/19/2007 4 □ Donation 5 □ Other (Specify) Alexandria, VA 21. Signature of Furreral S 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part | Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immed of Cause (Final disease or condition resulting in death)

a. Due to (or as a consciouence of): Approximate Interval Between Onset and Death OXVS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown is been signed by the should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 autopsy performed 2 No certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 ☐ Yes Division or this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave #1300; Chevy Chase, MD 20815 Frederick G. Barr, M.D.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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hierelsteen,

32 Registrar's Signature

			For State	State of N	Maryland /	-	artment			ind Me			007	00	nes
	Dhuciei	-	Registrar  1. Decedent's Name (First, Middle,	•			imoato	01 2	Catri		2. Date of Dea		Year	3. Time	of Death
	Physici /Medic	al	Ignatius F. Kwa		(r)		4h Cihi 3	Town or	Logation	f Dooth	Month 07	22	2007	118:	OGTM
1	Examin	er	433 Buttonwood		r)		Early		Location o	r Death		4c. County of Death			
	Funeral				Age (In yrs. last		If Under		ff Under a	24 Hrs. Min.	8. Date of Birt	h Y. Year)	Cecil 9. Birth Cou	place (State intry)	or Foreign
m <sup>6</sup>	Director		Usual Residence of Decedent	1 Months Days Hours Min. (Month Day Year) 9/10/1936									PA	7	
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36	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28s-f show other traumatic svent, the Medical Exacting must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes 25 If Yes, Give Year or Dates	s? ⊡ No		Was Deced f Yes, spec		spanic Orig , Mexican Specify:	gin? (Spec	cify Yes or No- lican, etc.)		Black, White		
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d 2	Hygie other t	e Co	17. Father's Name (First, Middle, Li	ist)		War	ehous			r's Name	(First, Middle,		Telepho	nie	
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Maryland	12 shou h and M 7 is mar trsumati		19a. Informant's Name/Relationshi John C. Ball	o (Type, Print)			2						Town, State, Zi	p Code)	
	s 1 and 3 f Health frem 27 other tr		20a. Mathod of Disposition		20b. Place	of Dispo	pencer sition (Nam	e of	- 1		nster,I		9 / 4 ation - City or T	own, State	
altimore,	Pages nent of ent; if it ary or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Holy		natory or ot 1 chre	ner piace		/1/0	7	Che1	tenham	Twn	PΔ
Balti	permit. Pages Department of Importent; If it any Injury or once.		21. Signature of Funeral Service Li	censee		22	. Name and		of Facility	Fell	ow, He	lfenb	ein & l	Newnan	1
			23a Part 1. Enter the disease, or c shock, or heart failure. List of	nly one cause on each	line.			, -	, such as	cardiac or	respiratory ar	rest,		Approxim Interval B Onset and	etween
3.0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			NEDI	n	12.	for	Char			3.00.	
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	be sit	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	ce of):	/								
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	8	Ď	Part II. Other significant condition	s contributing to death	but not resulting	g in the u	nderlying ca	iuse give	n in Part I.			obacco use 'es 2 🗆	e contribute to No 3 ☐ Pro	the cause of bably 4 ै	
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Zit.	Phyelclan: Th this certiticete ral director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	tions CDER	/O		Other	~		(Check only o				
o	ding Phye	$\vdash$	27. Manner of Death	1  fnpa 28a. Date of in (Month, D	ijury 288	Outpatien b. Time of Injury		Bc. Injury Work	4 🗆 IVUI		8d. Describe		Other (Speciocourred	<b>(y</b> )	
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ΟİΧ	rs after d al Direct ed in by	Certification:	4 Homicide determin	ed 286. Place of I	njury - At home, etc. <i>(Specify)</i>	, farm, str	eet, factory,	, office		2	8f. Location (S City or Tox		Number or Rui	al Route Nu	ımber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best ceminer: On the basis and manner	of examination	dge, death and/or inv	occurred a vestigation,	it the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the d d at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause	)(s)
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,	10		30. Name and address of person w	no completed cause of	death (Item 22)	a) (Tuna	Print	) 16	9 1			~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	14 23	, 00	
F	SYE		ALLAY CIARA	And add ad	MAN	111/1	IN H	os pit	AL	106	BUW	reel	, 9	LKNN	N
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature										

DHMH 17 Rev 1/2001

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ORIGINAL

07-05715	
Charles Lapp	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Ce	rtificate of De	ath		Reg. I	No.	JEJ CEU	-	
7	Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)     Charles	Edward	Lap	p, Jr.		2. Date of Death Month Da July 25, 200	ay Year	3. Time of Death 2242 hrs		
1			4a. Eacility Name (if not institution, give		4b. Cit		Location of Death	- Udily 20, 200	4c. County of Allegany	Death	_	
	Funeral Director		5. Social Security Number 6. Sex 213–86–3363 1X	7. Age (In yrs. M 2 F 43		Inder 1 Year onths Days		8. Date of Birth (1	16	9. Birthplace (State or Foreign Maryland Country)		
	any		Usual Residence of Decedent  10a. State 10b. County	10c. City	. Town or Location					10d. Inside City Limits	s	
	*	_	MD Alle	gany	Cumberlan	đ				1 X Yes 2 No	0	
1	reath with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 802 Gephart Dri		10f.	Zip Code	1502	10g.	Citizen of Wha	t Country? JSA		
-	LAL death with r r items 23:	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in L Armed Forces? 1 X Yes 2 No			panic Origin? ( Sp , Mexican, Puerto		14. Race - White,	American Indian, Black, etc.		
	E . E	by F	3 Widowed 4 XDivorced	If Yes, Give Year or Dates:		2 X No			Specify:	White		
	lours "natur Exam	ted	15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	y highest grade completed)  College (1-4 or 5+)	16a. Decedent's Us during most of		ion (Give kind of w DO NOT use retir		Sb. Kind of Busi	ness/Industry		
	036 thin 72 ne. • than edical	Completed	12	College (1-4 of 5*)	L	abore		5	Const	cruction		
	21215-0036 suld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)					(First, Middle, Mai				
e. up	2121 Ildibe f Mental narke event,	To Be	Charles 19a. Informant's Name/Relationship (Ty	Edward	Lapp, Sr		Jacque:	Lyn Ra Rural Route Numbe		orbin State, Zip Code)	_	
	MD 2 shouth and 1 27 is 1 amatic	-	Kelly L. Lapp /							land 21502		
4	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Department of Health and Meintal Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examini		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State	Place of Disposition ( crematory or other plant mberland (	ace)		Date 2 30/2007		City or Town, State		
^	Baltin permit. P Departme Importan		4 Donation 5 Other Specify: 21. Sign sture of Funeral Service Licens		22. Name	and Address	of Facility Ad		Ly Fune	ral Home, P.A		
	Physician		23a. Part I. Enter the disease, or compl	cations that caused the death								
	/Medical Examiner			Atherosclerotic Due to (or as a consequence			ease compl	icating fer	ntanyl	Death	_	
		<u>_</u>	Sequentially list conditions, b									
		Examiner	cause. Enter Underlying Cause									
	fred, Effect the executed sphysician and the burial - transit		events resulting in death) Last d.	Due to (or as a consequence		<del>//37 13111 -</del>						
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2 ald	68 certi nding	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre  1 Live birth 4 Pregnant at time of d	2 Fetal de		Ectopic pregna	incy	23d. Date of d Month	lelivery Day Year		
6	. Box he death c y the atten hed for us	Phys	1 Yes 2 No 9 Unknown	9 Unknown	enculture in the under	luina anuaa	siven in Rest I	23e Did toba	cco use contrib	oute to the cause of death?		
98d,	ires that the d signed by the	by	Part II. Other significant conditions	contributing to death but not	resulting in the diluen		given in Fait i.		2 No 3	Probably 4 Unknown	_	
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jar	n of ading Pl. h. After e funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury FOUND:		ry at Work? Yes 2 ✓ No	28d. Describe how	w injury occurre	5		
1	Division of Vipital or Attending Phours after death.  Beral Director: After if filled in by the funeral	ertification:	2 Accident Investigation 3 Suicide 6 X Could not be determined	28e. Place of Injury - At			uilding, etc.	unk 28f. Location (Str or Town, Stat 802 Gephart Dr.		r or Rural Route Number, Cit	ty	
*	Hos Fur	ledical Ce	29a. Certifier 1 Certifying Physicia	an: To the best of my knowle On the basis of examination	dge, death occurred a	it the time, da	ate and place, and	due to the cause(s	s) and manner a	as stated.		
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens				d (Month, Day, Year)		
			Aplina Bra	self MD	m 22al	O.C.	M.E.		July 26,	2007		
			30. Name and address of person who of Assistant Medical Exam		<sup>m 23a)</sup> eet, Baltimore, M	D 21201						
	S	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	tage Again	j						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:20 P July 29 2007 Helen Louise Lakin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) Feb. 8, 1916 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Maryland 1 □ M 2√E F 91 215-26-1644 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Frederick Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 2 and 1 piny or other traumatic event, the Medical Examiner muss 1—1000. 21701 U.S.A. 210 South Carroll Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give 11 Marital Status Black, White, etc. XXNever Married 2 ☐ Married Specify: White 1 □ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Factory Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Brown John Henry Lakin ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1440 Taney Ave., Frederick, Maryland 21702 Ms. Melanie Bryan, Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Aug. 2, 2007 Jefferson, Maryland Reformed Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Reeney and Address of Bastord PA Funeral Home Richo MOO255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTORN SCLUBELTIC CUMBIONASCULAR DISCHSE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) certificate be Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If ves. outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4☐Pregnant at time of death signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown HYPERTONSION page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an CONCESTIVE HOURT FAILURE autopsy performed? Yes 2 No 1□ Yes Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 30/07 D32171 P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

PO BOX

32. Registrar's Signature

WALKERSUILLE, MD

GU1964

RICHARD 31. Date filed (Month, Day, Year) AUG 0 3 2007 21793

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** July 23, 520 A Liller, Sr. Clyde Alvin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Oak Land Garrett 2801 Underwood Road 8. Date of Birth (Month, Day, Year) Dec. 18, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□F 80 Yrs. 1926 Maryland Dec. 213-24-6472 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "naturel", or Items 23a or 28e-f show digal Examirer is ust be notified at 1 ☐ Yes 2X No Director 0akland MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21550 USA 2801 Underwood Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII 3 Widowed 4 Divorced al Hygiene. d other than "nature event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner Coal Miner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic evone. Belle Moon 0wen Liller Mary Errice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2801 Underwood Road, Oakland, Maryland 21550 Vesta V. Liller/ Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/26/07 Oakland, Maryland Pleasant Valley Cem. A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Dicentee 32 S. Second St. Stadle Stewart Funeral Home Oakland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months disease or condition resulting in death) congestive heart failure /Medical Due to (or as a consequence of) Examiner atherosclerotic cardiovascular disease yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown chronic obstructive pulmonary disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Parkinsons disease autopsy performed? 2 No 1 ☐ Yes 2 🔀 No 1 Tes Division of Vital Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 512 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥No 0 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Xaturai 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a: To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signa ura and title of certifier 29c. License number D30035 07-23-2007 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Donald R.Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 32. gistrar's Signature 31. Date fifed (Month, Day, Year) State JUL 26 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11:55 pm July 17 2007 Hazel Iona Lancaster 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days 1 □ M 2 1 ₹ F 1924 Oct. 23, 129-18-8925 MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 2 No Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 2900 Brightseat Road #203 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: **Black** 3 NWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Cashier Woodward & Lothrop 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward Daphney Pearl Brown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Wood/Daughter 720 Fairmont St NW, Washington, DC 20001 20b. Place of Disposition (Name of cometery, crematory or other place Lakemont Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-23-2007 Davidsonville, MD
22. Name and Address of Facility Marshall's Funeral Home, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licensee 4217 9th Street, NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endispulmonary Due to (or as a consequence of): Sepsin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a o nsequence of) Assirot Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2[ 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 patient 2 ER/Outpatient 3 DOA

Examiner The law requires that the death certificate be executed P.O. Division of Vital Records, or Attending Physicien:

Physician/Medical Examiner use as the burial-transit physician and for detached þ pe page 2 should Be Completed Certification: To the in by 1 filled Medical

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be

Physician

/Medical

Examiner

10a State

MD

**Funeral** 

Director

28e-f show

0 Items 23a

ō

\*natural',

al Hygiene.

Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event. ODGE.

**Physician** /Medical

Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 is marked ott

permit.

the Medical Examiner must be notified at

Director

Completed by Funeral

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

has t this certificate After within 24 hours after death. To the Funerel Director: A To the Hospitel completely

State Registrar nichael

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Cheverly MD

28d. Describe how injury occurred

of death (Item 23a) Type, Print)

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 2 Year **Physician** 75AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bent ree War Anna Ar Anapolis
If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 □ F Yrs. York Director 086-20-0836 79 05/14/1928 New Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Anne Arundel Annapolis the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be no Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. 964 Bent Tree Way 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give Year or Dates: 1951-56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 Divorced White Completed the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physicist U.S. Government 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Lundsten Martha Bergeron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 964 Bent Tree Way, Annapolis, Maryland 21401 Virginia Lundsten item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/19/2007 | Edgewater, Maryland Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 100 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autonsy performed? Yes 2. No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 402 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) CU Besta

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year

JUL 2 0 2007

egistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year HELEN L. LEISS JULY 2007 16 2149 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TALBOT MEMORIAL HOSPITAL EASTON 8. Date of Birth (Month, Day, SEPT. 7,1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 X F 82 042-32-0617 NEW YORK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD 1√∑Yes 2 □ No TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31066 SKIPTON CORDOVA ROAD 21625 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PAUL K. CHRISTMAN HELEN C. SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 165, CORDOVA, MARYLAND 21625 PAMELA S. HELMER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 7/18/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trian) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐MC 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notified at

'natural", or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural" ~ in any injury or other traume.

Director

Funeral

Completed by

Be

2

with the Maryland

and attending physician

Examine Completed by Physician/Medical Be 2 within 24 hours after death.

To the Funeral Director; After completely filled in by the funeral Certification:

or Attending Physiclan: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

1 ☐ Yes 2 ☐ No 27. Manner of Death 1 D Natural

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0040274

29d. Date signed (Month, Day, Year) 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8579 Commence Du, EHSBN, MD 2/661 I. Allen Webb, MD

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 1 8 2007



CI+IVA

			For State Registrar	State of	Maryland / Dep	artment of F		Mental Hy	giene Reg. No.	2007	25102
	e Tr	va.	Registrar     Decedent's Name (First, Middle, I	_ast)		Timodio oi		2. Date of De		0	3. Time of Death
	Physici	- 4	PAULINE MAF		LOCKE			July 20	Day 2007	Year	1:15 A M
	/Medio		4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Dea			County of Death	
	Examili	er	MONTGOMERY VILLAGE H			MONTGOMER	Y VILLAGE		MON	TGOMERY	
	Funeral			Sex 7	. Age (In yrs. last birthday	) If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth	9. Birth	place (State or Foreign
	Director		578-26-7362	1□M 2⊠F	82 Yrs.	Months Days	Tiodis Will	May 23,			ngton, DC
	P .	22	Usual Residence of Decedent		10c. City, Town or L	and in					10d. Inside City Limits
	arylar show d at	-	10a. State 10b. County			ocation					1 ☐ Yes 2X No
	Ba-f	Director	Maryland Montgome	ery	Rockville	101 7: 0 1			10= Cities	en of What Cou	ntn:?
	vith the	Dir	10e. Street and Number			10f. Zip Code					nu y r
	s 23s	sral	13207 Vandalia Driv		lent Ever in U.S. 13.	20853	dienanio Origin?	(Specify Ves or N		S.A. 4. Race - Ameri	can Indian.
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Ford		Was Decedent of I If Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)		Black, White,	etc.
36	rs aff	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	)	1 ☐ Yes 2 No	Specify:			Specify: Whi	te
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	ed	15. Decedent's	Education		edent's Usual Occup			16b. Kin	d of Business/In	dustry
15	nin 72 n "ne Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	life.	e kind of work done DO NOT use retire	during most of w d)	orking			
212	filed within Hygiene. Ither than "	E	7	College (1-		il Clerk			U.S.	Postal S	ervice
ğ	il Hygi other /ent, tl	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's N	ame (First, Middle	e, Maiden S	Surname)	
<u>a</u>	should be fand Mental I s marked of umatic eve	To E	Gabriel D'Addario	)			Pauline	e Margaret	Petr	ello	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street	and Number or	Rural Route Numi	ber, City or	Town, State, Zi	p Code)
	1 and 2 Health em 27 I		Juanita M. Bourne/	Daughter		Canary Cour	t, Ijamsv				
Baltimore,	es 1 se of 法er item		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3	□ Removal from S	20b. Place of Disp cemetery, cri	osition (Name of ematory or other pla	Jul	Date y 24	20c. Loc	ation - City or T	own, State
<u><u>ĕ</u></u>	permit. Pages Department of I Important: If ite any injury or of once.		4 □ Donation 5 □ Other (Spe		Gate Of He	aven Cemete	- 20	07			Maryland
ä	permit. Departi Importa any inj once.		21. Signature of Funeral Service Li	cent ee	+ :	22. Name and Addre	ess of Facility H	ines-Rinal	li Fune	ral Home.	Inc.
	9 9 E 2 9		Maney A	. Vance	~ ~~	1800 New Ha				ing, MD A	Approximate Interval Between
8760,	Certificate be executed ding physician and physician and se as the purial-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List of limited the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any heart of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End St  Due to (c  Anemia  Due to  c  C. Hypert  Due to (c	age Metastatic or as a consequence of): or as a consequence of):	Cholangio (					Onset and Death
.O. Box 6	death e atter ed for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1□Live bi	ant at time of death 5	□Ectopic pregnand □ Other (specify) _	гу	7	2	3d. Date of deliv	very Day Year
σ,	requires that the een signed by th nould be detache	by PI	Part II. Other significant condition	s contributing to de	ath but not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Ş	quire an sig uld b	a b						_ 1 [	Yes 2	]No 3∏Pro	bably 4 🖺 Unknown
Records,	law re as bee 2 sho	Completed						24a. Wa		24b. Were aut	opsy findings available ompletion of cause of
R	The la	E O						per	opsy formed? 2 <b>X</b> No	death? 1 ☐ Yes	
Vital	an: 'tifica'tifica'tor, p	Be C	25. Was case referred to medical		200		26. Place of D	Death (Check only			
>	Physician: The lav this certificate has ral director, page 2:	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Ir	npatient 2 ☐ ER/Outpati	ent 3 DOA Ot	her: 4⊠ Nursing	g Home 5 □ Re	sidence 6	Other (Spec	ify)
0		=	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o	of Injury 28b. Time h, Day Year) Injury		ury at ork?	28d. Describe	e how injury	occurred	
Division or	Attending r death. sctor: After y the funer	Certification:	2 ☐ Accident investiga	tion			]Yes 2 □ No				
Vis	r Atto	tific	3 Suicide 6 Could no 4 Homicide determin	ad Zoe. Flace	of injury - At home, farm, s ng, etc. <i>(Specify)</i>	street, factory, office	<del>)</del>	28f. Location City or T	(Street and own, State)	d Number or Ru	ral Route Number,
	spital or nours afte neral Dir / filled in	Çe									
	F Fu	Medical	29a. Certifier 1 ☑ Certifying (Check only one)  1 ☑ Certifying 2 ☐ Medical E	Physician: To the xaminer: On the bat and mann	best of my knowledge, de- usis of examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death o	ace, and due to th ccurred at the tim	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	o the ithin 2 o the omple	Med				29c. Licen	se number		29d. Date	e signed (Month	n, Day, Year)
	151		1 1 211	seati !	1	D 41	162		July 3	20. 2007	
	12"		30. Name and address of person w								
			Vinu Ganti, MD, 103				r Spring.	Maryland	20902		
×	St	ate	31. Date filed (Month, Day, Year)	32.	egistrar's Signature	1 4	, 0,				
	Regist		.111 23	2007	due & A	0842)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician PAUL LUDWIN JULY 10:20 A M 19, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 14514 HOMECREST ROAD LL12 SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1₩ M 2□ F 94 Yrs. 053-12-5380 10/11/1912 POLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location f show 10a. State r 28a-f show notified at 1x Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ō must be 14514 HOMECREST ROAD LL12 20906 23a U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. 1 Yes 2 No ARMY If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FASHION DESIGNER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MIRIAM "UNASCERTAINABLE" WILLIAM LUDWINOVICH ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 is
any Injury or other trau DR. LEONARD H. RAUCHER/GRANDSON 10085 WHITWORTH WAY, ELLICOTT CITY, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State NEW MONTEFIORE CEMTRY: 07/22/2007 PINELAWN, NEW YORK 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licensee Donald 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 XNo Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

• Funeral Director: # 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2. 2

altimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division or Vital

LUDUIN

State Registrar

M.D., ALPANA GØSWANI, 31. Date filed (Month, Day, Year) JUL 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

11125 ROCKVILLE PIKE, SUITE 110, ROCKVILLE, MARYLAND 32. Registrar's Signature

29c. License number

D027760

29d. Date signed (Month, Day, Year)

07/19/2007

			1 _ For State	State of Ma	iryland / l	Departme <i>Certifica</i>			_	-	6.007	25/04
			1. Decedent's Name (First, Middle, Las	;t)		Oertino	ile oi L		2. Date of De	Reg. No ath	0.	3. Time of Death
	Physici		Donald Peter	Lanser					July 2	.5 <b>.</b>	y Year 2007	1237 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. Ci	ty, Town, or	Location of Death		-	c. County of Death	
			Garrett County Me	morial Hos	pital		0akl	and.		Garrett		
	Funeral		5. Social Security Number 6. S	<b>X</b> 5 C = 1	(In yrs. last bir	Month	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v. Year	9. Birth	place (State or Foreign intry)
	Director		393–28–5170 Usual Residence of Decedent	201	75	Yrs.			Dec. 7,	19:	31 Wis	consin
	land ow		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
	Mary Help	to	KS Johns	on		01	athe					1 XYes 2 □ No
	r 28s	Director	10e. Street and Number			10f.	Zip Code			10g. C	itizen of What Cou	intry?
	th wit	aiD	15822 W. 143rd Te	rrace				66062			USA	
	r dea	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	cedent of His	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	。 Korean		2[ <b>X</b> No	Specify:	,		Specify:	White
8	within 72 hours after death with the Maryland ene. then "naturel", or itema 23s or 28s-f ehow in Medical Exeminer must be notified at	ed t	15. Decedent's Ed			Decedent's U	sual Occupat	tion		16b k	Kind of Business/li	oduetry.
212	n n n	Completed	(Specify only highest gra	de completed) College (1-4or 5-		(Give kind of life. DO NO)	vork doné du	uring most of wor.	king	100.1	Cirilg Of Dusinessan	idd str y
2	giene giene r the	E	Cionionaly/Obcordary (0-12)	1	<del>-</del> )	Sale	Repr	esentati	ve	Au	tomotive	Sales
nd	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maide	n Sumame)	
<u>ya</u>	Ment Ment arke	P	George	Lanser				Pearl			Sta	rk
Mar	12 sh h and 7 ie m traum	¥ Ì	19a. Informant's Name/Relationship (7								or Town, State, Zi	
e,	1 end Healt em 2		Patricia O. Lanse 20a. Method of Disposition	r/ wire				. Terrac	Date Olat		Kansas .ocation - City or T	66062
Baltimore, Maryland 21215-0036	Pages nent of int: if it iry or c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1 -	f Disposition (A ry, crematory o rection	_	7/2	8/07		athe, KS	
Balt	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Extending must be notified a once.		21. Signature of Funeral Service Licen	Dead			and Address	of Facility neral Ho			Second and, MD	St. 21550
			23a. Part1. Enter the disease, of comp shock, or heart failure. List only	lications that caused	the death. Do i	not enter the m	ede of dying	, such as cardiac	or respiratory ar	rest,	4	Approximate Interval Between
į	Physician		Immediate Cause (Final disease or condition	Λ	LUGGA	volal	16-	Facto	10			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	100	/ -[010				
	Examine		Sequentially list conditions,	b		0						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	or):						
	al-trai	xar	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):						
68760,	ificate be executed g physicien and as the burial-transit	edicai		d								
		fedi										
Вох	eath certifi ettending p for use as	an/N	200. Has decedent pregnant	23c. If yes, outcome of		3 ⊟Ectopic	ргеплалсу				23d. Date of deliv	
О. П	that the dea led by the et detached fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t 9□ Unknown		5 Other (					Month	Day Year
σ.	that the ded by	Ph	Part II. Other significant conditions co	ontributing to death bu	t not resulting in	n the underlying	cause giver	n in Part f.	23e. Did to	obacco	use contribute to	the cause of death?
Division of Vital Records, P.O.	w requires that the death cen been signed by the ettendin should be detached for use	ed by							1 🗆 Y	/es 2	□No 3□Pro	bably 4 oknown
ecc	aw as b	Completed							24a. Was autop	an	24b. Were aut	opsy findings available ompletion of cause of
<u>~</u>		Con							perfor	STS/No	death?	
Vita	rician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hoosital:			1	26. Place of Dea	th Check only o	nel ,		
of	Phys this ral dir	2	1 Xes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury				4 □ Nursing H			6 ☐Other (Speci	fy)
Ö	ding After fune	tion	1 SNatural 5 Pending 2 Accident investigation	(Month, Day	Year) 200. I	Time of njury M	28c. Injury a Work?	es 2 🗆 No	28d. Describe h	iow inju	ry occurred	
/ISI	or Attendation after deati	fica	3 Suicide 6 Could not be	28e. Place of fnjur	ry · At home, fa				28f. Location (S	Street a	nd Number or Rur	al Route Number,
á	spitel or A cours after neref Dire	Certification:	4 Homicide determined	building, etc.	. (Specify)		,		City or Tow	m, State	9)	
	한 수 필 후	edicai	29a. Certifier t Certifying Phyone Check only one Certifying Phyone  ysician: To the best of iner: On the basis of and pranner stat	examination ani	, death occurre d/or investigation	d at the time on, in my opio	, date and place, nion, death occur	and due to the or red at the time, o	cause(s date an	) and manner as : d place, and due t	stated. o the cause(s)	
	To the within 2. To the complet	×	29b. Signature and title of certifier			2	9c. License			29d. Da	ite signed (Month,	
!			1/ 1/4/	1				D23979			7/25/07	7
			30. Name and address of person who o								1550	
	Sto		Dr. Robert Gorals 31. Date filed (Month, Day, Year)	ki, MD 3		ourth S	st., 0	akland,	Marylane	d 2	21550	
	Sta Registra			007	es de	Social	D					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 2:00 M Facility Name ( City, Town, or Location of Death last birthday) 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No 10e. Street and Number 10g. Citizen of What Country? LSA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Naustave Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee mmie 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final terroscherotic disease or condition resulting in death) ears Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2 🗆 No Yes

**Physician** /Medical Examiner

burial-transit

attending physician for use as the burial

ed by the a

P.O. Box 68760

Division of Vital Records.

Examiner

Physician/Medical

9

Completed

Be

Certification:

Medical

**Physician** 

/Medical

Examiner

10a. State

**Funeral** Director

28e-f show

Director

Funeral

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item 27 is marked other then "neturel", or items 23e or 28e-f show other treumstice event. It is Medical Examinating to a notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other then "sany injury or other treumatic event, Item Nac

the Maryland

death

3altimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manner of Death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

f death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 - Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

30 Name and address of person who

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

BAG

To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After

State Registrar

A. DEVORE MD

6 Could not be

4203 Queensbury Rd Hyattsville MI

			1 - For State Registrar	10000	State of	of Marylar		artmen			nd Me	-	giene Reg. No.		2510	)6
	Physici	100	Decedent's Name (First     Den 7		)			ii en	cho	747		2. Date of De		Year 07	3. Time of De	
	/Medic Examin		4a. Facility Name (If not in		street and nu	mber)			Town, or	Location o	f Death		4c. Cour	nty of Death		
	ZXGIIII.		17848 Garre	tt Hig	hway			Oa:	k1ano	i			Gar	rett		
	Funeral Director		5. Social Security Number 175-44-6591	i	х ] м 2Д¥г	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da )ec. 9,	th y, Year) 1953	Cou	olace (State or Fo ntry) nsylvani	
	D .		Usual Residence of Deced	dent County		10c G	ty, Town or Lo	ocation							10d. Inside City L	imits
	sho	5		•				Joanon							1 ☐ Yes 2	
	he N	Director	MD G  10e. Street and Number	arrett		0.	akland	10f. Zip	Codo				10g. Citizen o	f What Cou		Λ
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ဗ္ဗ	urs a		3 ☐ Widowed 4 ☐ D	vorced	If Yes, Gi Year or E	ve		1 🗌 Yes	2 <b>∑</b> No	Specify:			Spec		ite	
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show na Medical Examinar must be notified at	Completed by	15. D	ecedent's Ed	ucation le completed)		16a. Dece	dent's Usu	al Occupa	ation Juring most	of workin	a	16b. Kind of	Business/Ir	ndustry	
21	thin 7	nple	Elementary/Secondary		College (		life.	DO NOT U	se retired	)	Or WOMEN					_
7	filed wi Hygien Sthar th	S	12				Owner	r & 0	perat						rv. & Mo	tel
밀	be fil ital H id oth	Be	17. Father's Name (First, I										Maiden Sum	ame)		
<u>\</u>	I Men Parke	ျ	Allan Byron									lilliam				
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Re					•					er, City or Tow			
e,	1 and Healt em 2 ther	1 8	Mr. Jeffery 20a. Method of Disposition		now, H		1/84 Place of Dispo			Higi		Uakla	nd, MD			
סר	Pages nent of I ant: If its ury or o		1 □ Burial 2 🗡 Cren	nation 3 🔲		State	cemetery, crei	matory or c	other place	· 1	7 / 20 /	'07				
Baltimore,	교육관금 .		4 Donation 5 C			Cu	mberlar					-	Cumbe		, MD	
Ba	Depa Impo Impo eny lo		Kather	لا ن	weitzer			21 N	I. Se	cond	St.,	0akla:	1 Home, nd, MD	P.A. 21550		
9		b	23a. Part1. Enter the dise shock, or heart failur	ase, or comp e. List only o	lications that	caused the dea each line.	th. Do not ent				1	respiratory a	rrest,		Approximate Interval Betwee Onset and Dea	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a. Sm	all	cell	CRY	cer	0	1	ung			3 drs	
	Examiner		,		Due to	(or as a conse	quence of):									
1	pe lisi	Examiner	Sacuantially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	te d	Due to	(or as a consec	quence of):									
	te be executed ysician and e burial-transit	xan	that initiated events resulting in death) Last		c Due to	(or as a conse	quence of):							, ,		
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ŏ	n cert andin use	<u>N</u>	IF FEMALE: 23b. Was decedent pregn	arrit		itcome of pregn		∃Ectopic p	rean 2001					Date of deliv	-	
.O. Box	Attanding Physician: The law requires that the death certificate be executed robath.  crosath.  cross Atter this certificate has been signed by the attending physician and sy the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	s?	_	nant at time of		Other (s			-		_	Month	Day Yea	1f
o. O.	ss that gned to	by P	Part II. Other significant of	onditions co	ntributing to d	death but not re	sulting in the u	inderlying o	ause give	en in Part I.			_		the cause of deat	
ord	w require been si should b							_				1 🖭	Yes 2□No	3 🗌 Pro	bably 4 □Unk	inown
Division of Vital Records,	e taw n has be je 2 sh	Completed										24a. Was	an 24l	b. Were aut	opsy findings ava	arlable se of
œ =	The page	Cou										perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	212 No	
Ę	iclan	Be	25. Was case referred to examiner?	-	Hospital:							(Check only				
o	ding Physician: The in.  After this certificate hat tuneral director, page	٠ <u>.</u>	1 Yes 2 No				ER/Outpatier						dence 6 C		(y)	
C	ding h. After funer	tion	1 🗷 Natural 5 🗆	Pending investigation	(Mor	of Injury oth, Day Year)	Injury	M	28c. Injury Work	rai ⟨? Yes 2 □ i		ou. Describe	now inquity occ	,u1160		
18	after deat Director: In by the	fica	0 000000	Could not be determined	28e. Plac	e of Injury - At h	iome, farm, sti					8f. Location (	Street and Nu	mber or Rui	al Route Number	ır,
2	talor/ rs after al Dire	Certification:	4  Homicide		build	ling, etc. (Speci	·fy)					City or To				
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 (Check only 2 None)	ertifying Phy ledical Exam	iner: On the b	e best of my kn pasis of examin nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time, in my of	ne, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of	certifier		/	7	29	c. License				29d. Date sig	ned (Month	Day, Year)	
}			1. st	an	oxer	onto	prof		1	42	46	54	7/	25	107	
			30. Name and address of									,	1	1		
	~ 4-		Dr. Sotiere			1100	. Four	th St	., 0	aklan	id, M	D 21550	U			
4	Sta Registi		31. Date filed (Month, Day		2007	Registrar's Sign	ALUIN A	Cooks	£							

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П	Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of Death Month	Day Yea	3. Time of Death		
	/Medi		Jack McKinsey							24 2007	16:58 ™		
ž	Examir		4a. Facility Name (If not institution, g		nber)		4b. City, Town, or	Location of Death		4c. County of Death			
			Charlotte's Ho	me			Boonsbo	oro		Washington			
	Funeral			Sex 1X M 2 ☐ F	7. Age (In yrs. la	- "	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. B	Sirthplace (State or Foreign Country)		
	Director		218-18-7886	IAN ZUI	91	Yrs.			Jan. 22		ryland		
	and		Usual Residence of Decedent  10a. State 10b. County		10c, City	, Town or Lo	cation				10d. Inside City Limits		
	Aaryl Feho	ŏ		. 1	,						1 Yes 2 No		
	28a-	Director	Maryland Freder  10e. Street and Number	1CK		Fred	erick		140	0111			
	with						10f. Zip Code		10g	. Citizen of What (	Country?		
	eath	era	5601 D Avonshire		dent Ever in U.S	2 12 1	Vas Decedent of His	703		USA	nerican Indian,		
	Iter d	-un	1 Never Married 2 Married	Armed For	rces?		Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wh			
23	urs a	by Funerai	3 ₩ Widowed 4 Divorced	If Yes, Give	9	1	☐ Yes 2X No	Specify:		Specify:	171		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Itams 23a or 28e-f ehow int, the Medical Examinar must be notified at	Completed	15. Decedent's I	Education		16a. Deced	ent's Usual Occupa	tion	16	b. Kind of Busines	White		
75	hin 7	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-	Anres	(Give	kind of work done di OO NOT use retired)	uring most of work.	ing		,		
7	d with	E O	10	0	-401 34)	Trai	ner - rac	e horses		Race Tr	ack		
힏	otho Vent,	BeC	17. Father's Name (First, Middle, Las	()					First, Middle, Mai		ack		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itams 23a or 28a-1 ehow way injury or other traumatic event, the Modical Examinat must be notified at ADE.	ToE	Hiram Maurice Mc	Kinsey				Rlan	che Wolf				
ar	ema		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street ar		al Route Number, C	ity or Town, State,	, Zip Code)		
	elth c		Judy Harshman - 1	Daughter		5601	D Avonshi	re Place	Frederi	ck MA	21703		
altimore,	of He item		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of place	, , , , ,	Date 200	c. Location - City of	or Town, State		
Ĕ	Page nent c nt: If ry or		1 ☐ Burial 2 【Cremation 3 if 4 ☐ Donation 5 ☐ Other (Spec		JIAIO		Cremato	i	/07				
븚	nait. Dontin Poorts / inju		21. Signature of Funeral Service Lice	ensee	mage	22	Name and Address		innich Fu		, Maryland		
Ö	Depa Impo any ii		1200X	+/NV	Minne.	(10)	-1	ri.			me <u>wn, Md. 21740</u>		
			23a. Part1. Enter the disease, or cor	nplications that ca	used the death.	Do not ente	or the mode of dying	, such as cardiac	or respiratory arrest,	,	Approximate		
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ach line.		0	(			Interval Between Onset and Death		
7	/Medical		disease or condition resulting in death)	a Club	or as a conseque	20 CU	lai la	cudent	-				
	Examiner	i		Lì	_	erice or).					655		
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	uted J ansit	들	cause. Enter Underlying Cause (Disease or injury that initiated events										
~	exec n an ial-tr	Examiner	resulting in death) Last	Due to (c	or as a conseque	ence of):							
68760,	icate be executed physician and s the burial-transit	edical		d.									
_		edi											
Rox	death certific e ettending p id for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnan					23d. Date of de	elivery		
	deatl	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	nth 2 ☐ Fetal o ant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year		
Ö.	at the de by the tached	hys	9 Unknown	9∐ Unkno	wn								
	The law requires that the te has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions	contributing to dea	ath but not result	ting in the un	derlying cause giver	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?		
ecords,	quire n slg uld b	D D							1 ☐ Yes	2 □ No 3 □ F	Probably 4 Dunknown		
၀	w require been sli should l	jet							24a. Was an	24h Were a	autopsy findings available		
r	The lav	Completed					·		autopsy performed	d? prior to	completion of cause of		
VItal		ပိ	25. Was case referred to medical					00.51 (5.4)	1 ☐ Yes 2 ☐	Ho 1 □ Ye	es 2 No		
	Physician: r this certific ral director,	0 13	examiner?	Hospital:	patient 2 E	R/Outpot ont	Other	26. Place of Death			A 1		
ō	Phys arthis aral di	⊢⊦	27. Manner of Death	28a. Date of	f Injury 2	R/Outpatient 28b. Time of	3LJ DOA	4   Nursing nor	ne 5 Residence		ecity) 733 . LIV.		
0	ding Ph th. After thi funeral	5	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	n, Day Year)	Injury	28c. Injury a Work? M 1 ☐ Ye	es 2 □ No		,,			
DIVISION	al or Attending F effer death. I Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not b	ое Пи	of Injury - At hom	ne, farm, stre			28f. Location (Stree	t and Number or F	Rural Route Number.		
5	efte efte din b	ert	4  Homicide determined	buildin	g, etc. (Specity)		,,		City or Town, S				
	spits nours neral	<u>ا</u> ۾	29a. Certifier 1 Certifying P	hysician: To the !	best of my knowl	ledge, death	occurred at the time	date and place a	and due to the cause	e(s) and manner a	as stated		
	P Fu	ledicai	(Check only 2 Medical Exa	miner: On the bas and manne	sis of examinatio	on and/or inve	estigation, in my opin	nion, death occurre	ed at the time, date	and place, and du	ue to the cause(s)		
	To the Hospital or Atta within 24 hours efter de To the Funeral Direct completely filled in by the	Me	29b. Signature and title of certifier				29c. License	number	29d.	Date signed (Mor	nth, Day, Year)		
)			- 200	~0			DIB	019	2	ULY 2	7.2007		
		-	30. Name and address of person who	completed cause	of death (Item 2	23a) (Type F	rint).			,	,		
5	H-3		DR. VASADT	DATT		mill	1-1	CELLT	wp mi	2174	^		
	Sta	е	31. Date filed (Month, Day, Year)	32. Re	ajstrar's Signatu			10	WP III	- 41 /7			
3.	Registra	ar	JUL 26	2007	Bottom !	1. 1	and a						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 07 Day **Physician** 20 1910 /Medical 4a. Facility Name (If ηot institution, give street and number) 4b. City, Town, or Location of Death Gounty of Death Examiner HOSPICE Wicomicc Salisbur (a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2**X** F Director 234-22-6187 9/1/1918 89 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural?" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be accessed. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Newark MD Worcester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21841 USA 6744 Basketswitch Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Grandstaff Ella Ashby ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Grinath / daughter 905 Holly Swamp Rd., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 7/23/07 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHRIMERS **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTRUSIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUBOX1733 SALISBARY MD. 21802 OHUMM WARIS HOSPICA COASTAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 3 2007 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year William Wesley Mullineaux July 2007 /Medical 22 0950 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2∏ F 80 216-20-3771 Director Feb 03 1927 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at Director MD Carroll Westminster 1 TyYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 170 Alymer Court USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 □X/es 2 □ No ₩₩ ፲ ፲ If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other th any Injury or other traumatic event, thu once. Teacher Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillian Liebno Irvin Mullineaux 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Mullineaux/wife 170 Alymer Ct Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 07/2772007 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signature of Funeral Service License Printer Admentic Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enache disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause it, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: Af 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1316G

WHY

State 31. Date filed (Month, Day, Year)
Registrar

EALYNIN DOI STEWER AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 2007

DHMH 17 Rev 1/2001

WESTMIN STER MARLIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Pate of Death 3. Time of Death Day **Physician** Essie Lorraine Mayfield 4:20 AM 2007 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince Georges Lanham If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 21 F Director 72 227-42-5699 Sept.19,1934 Suffolk, Va. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at Director Maryland Prince Georges Capitol Heights 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 7700 Beechnut Rd. 20743 Funeral United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical Egone. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Daycare Director Private 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Lee Jones ပ Veoma Wiggins 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Indica Mayfield Harley 7501 Leona Street Forestville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Aug. 8, 2007 Arlington, Va. 21. Signature of Funeral Se 🖟 Licensee 22. Name and Address of Facility Alexander S. Pope, P.A. 5538 Marlboro Pike/Forestville, Md. 20747 M01085 23a. Part. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Henah disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical aftending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 🖫 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient Certification: To Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death

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32. Registrar's Sign total

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(Item 23a) (Type, Print) DPINDER SINGS M.S.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Henry C. Martin 2007 Ju1v 6:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehab Annapolis 4 8 1 Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 14 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 1922 Days Hours 1**X** M 2 □ F 233-14-0088 Pennsylvania Director Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Anne Arundel Annapolis TY∐Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or 5 ns 23a c must br 31 Dorsey Ave 21401 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23:
Inty or other traumatic event, the Medical Examiner must Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th <u>Boiler Attendant</u> Plastic Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnny Martin ဥ Mattie Unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Sherrod(Friend) 113 Holeclaw St. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Memorial Park 7-17-07 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licensee Windame Reduces of RacilBons Mortuary, P.A. MO0483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 4 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 D Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 UN ural 5 Pending • Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

e Funeral I Within 2 2

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

OCOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 2 0 2007

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 1 6 2007

MD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month JOHN MURLAS 00:47AM Juli 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUM BIA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT - 17, 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F UTRGINIA Director 215-48-5007 59 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exa⊡iner must be notified at 1 Yes 2 No Director MARYLAND HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6334 CEDAR LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CENTERS FOR THE College (1-4or 5+) Elementary/Secondary (0-12) HANDICAPPED SPECIALIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be **BESSIE GEORGE** ဂ GEORGE P. MURLAS and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra 2900 N. LEISURE WORLD BLVD. #408, SILVER SPRING, MD BESSIE MURLAS/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/07/2007 ARLINGTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 21. Signatura of Funeral Service Licens cations that caused e cause on each li 23a. Part1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 1/2 assive lest day disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ending physician and use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1∐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To nours after death.

neral Director: After this
filled in by the funeral di After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

MD, FCCF D 36845 30. Name and oldress of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

haugen, 31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

JULY 19, 2007

State Registrar

2007

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year DANIEL MUTAI July 21 704A 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS CITY HUSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1(XM 2 □ F 48 217-98-9484 8/22/1958 Israel Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Montgomery Potomac 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11804 Smoke Tree Road 20854 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. White 3 ☐ Widowed 4 ☐ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Self Employed Jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Menachem Mutai Orah Soleimanzadeh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moshe Mutai - Brother 237 Blaze Climber Way Rockville MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Lebanon Cemetery 7/22/07 Adelphi, MD 21. Signature of Funeral Service Lie 22 Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final pneumonia 2 Wears disease or condition resulting in death) Due to (or as a consequence of) Chronic myelogenous Leukemia Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Department of Health a
Important: If item 27 Is
any Injury or other trai

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Box 68760.

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Division or Vital Records,

**Funeral Director** 

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

26. Place of Death (Check only one)

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? Yes 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

Hospital: 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28h Time of (Month, Day

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 🗌 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 🗆 No

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

(Check only one) 29b. Signature and title of certifier

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES-000

21, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN ALONSO, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFESTROOT, BAITIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year)

JUL 23 2007

State Registra



. Celonso, MEDICAL DECTOR

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 15 **Physician** 2315 Orvilla P. Offer July 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Apr 26 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2√2 F 89 Yrs. 1918 Pennsylvania 185-10-6899 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State ns 23a or 28a-f show must be notified at 1X Yes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 USA 1014 Tallwood Rd. Apt 1D Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) T is marked other than "natural", or Items traumatic event, the Medical Examiner me 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2¶ No Specify: Black Baltimore, Maryland 21215-0036 Specify þ 3√Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. College (1-4or 5+) Elementary/Secondary (0-12) Board of Education Teacher 12th 6vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Orvilla Groves William Plater 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 335 North 52 St. Philadelphia, Pa 19139 Judith Merrill(Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Idemotery Cremstary or other place) Pages 1 permit. Pages Department of Important: If It any Injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 7-20-07 Annapolis, Md. Memorial Gardens 4 □ Donation 5 □ Other (Specify) Williame Recorded & Cilicons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry 821 West St. Annapolis, Md. 21401 M0048 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 (No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has 1□ Yes 2 D No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1/ Inpatient 3 □ DOA 2 ☐ ER/Outpatient Certification: To mpletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannér of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Point) Registrar's Signature 31. Date filed (Month, Day, Year) State 2 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 19, 2007 **Physician** 2:08 PM **JOANNE** O'HARA July MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 🕅 F 72 216-32-4599 June 23,1935 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Derwood Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16401 Grande Vista Drive 20855 United States Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) Teachers Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F 7 is marked otl Estelle Kerber William Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trae 16401 Grande Vista Dr. Derwood, MD 20855 Mark A, O'Hara Jr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Baltimore, MD 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 05 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 1 Impatient ို 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hosp within 24 hou To the Fune completely fi

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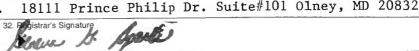
State Registrar

29b. Signature and title of certifier

Dr. Ata Motamedi M.D. 31. Date filed (Month, Day, Year) 23 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Motane



29d. Date signed (Month, Day, Year)

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		1	For State Registrar	Sta	te of I	Maryland		irtment <i>tificate</i>			and IV	lental Hy	giene Reg. No.	1. 1.	anny	00	1 1 7
			1. Decedent's Name (First, Middle									2. Date of De			Year	3. Time of	
	Physicia /Medic		Joan Wirth Ph	illips		J						July	16	5 2	2007	10:51	АМ
	Examin	31	4a. Facility Name (If not institution 7101 Bay Front		#424				Anı	napol	is	Anne Arundel					
	Funeral Director		5. Social Security Number 214–30–6334	6. Sex 1 ☐ M 2		Age (In yrs. le	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Di Dec . 18	th ay, Ye <i>ar)</i> 3, 19	32	9. Birthp Coun Mar	lace (State of try) yland	or Foreign
	aryland show d at	7	Usual Residence of Decedent  10a. State  Maryland  10b. County Anne	Arunde	el	10c. City	, Town or Lo	cation	Annapolis 10						0d. Inside C	•	
	vith the M t or 28a-f be notifie	Directo	10e. Street and Number 7101 Bay Front	Drive	, #42	4		10f. Zip	Code	214	03		10g. Cit	Citizen of What Country? U.S.A.			
30	be filed within 72 hours after death with the Maryland Hylyiene.  dother than "natural" or Items 23a or 28a-f show dother than "matural" or Items event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 ☒ Divorced	12. Wa		ent Ever in U.: es? XNo		Vas Deced f Yes, sped l □ Yes				ecify Yes or No Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. Specify: White			
9500-6121	filed within 72 hou Hygiene. Ither than "natura ent, the Medical E	Completed I	15. Deceder (Specify only highe Elementary/Secondary (0-12)		oleted) llege (1-4	(Give kind of work done during most of working life, DO NOT use retired)						16b. K	Kind of Business/Industry  Retail				
land 2	buld be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last)  Edward C. Kuhl  18. Mother's Name (First, Middle, Maid Gertrude C. Wirtl														
Mary	She in the		19a. Informant's Name/Relations Kurt Phillips/		1131 Old Stone Lane Arnold, Mar								ber, City o	ty or Town, State, Zip Code) ryland 21012			
altimore,	jes 1 and 2 t of Health a if item 27 is or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Remov	al from St	are i	lace of Dispo emetery, crea			1		Date				own, State	3
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Division or	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the t	Certification:	3 Suicide 6 □ Could	not be mined 28	e. Place o buildin	of injury - At h	ome, farm, st	reet, facto	ry, office			28f. Location City or T	(Street a own, Sta		ber or Ru	ral Route Nu	mber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certify	I Examiner:	n: To the l On the ba	sis of examina	owledge, dea ation and/or i	nvestigatio	n, in my	opinion, de	eath occi	e, and due to thurred at the tim	e, date a	nd place,	and due	to the cause	
)	To the vithin 2 To the complete	Ň	29b. Signature and title of certif	& Ha	Ste	Jun				se number		- 1				2007	
	(de)		30. Name and address of person	h who comple	ted cause	of death (Iter	m 23a) (Type	(de	va t	er Co	lon	y Drive	An	rap	oler	KD 219	401

State Registrar homes

JUL 1 9 2007

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1- State
Registrar 1. Decedent's Name (First, Middle, Last)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland

/ Department of Health and	Mental Hygiene
Certificate of Death	Reg. No.

2. Date of Death

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3. Time of Death

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

sicia edic		Bessie Pokodner				7/15/2	2007	9:17pm <sup>M</sup>	
mine	и'	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea		
		Crofton Convalescent Center		Croft		0.0-140:4	Anne Ar		
ral tor		5. Social Security Number  087–16–6889  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last bi	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 9/27/19:	Year) 9. Bii	thplace (State or Foreign ountry) NY	
	tor	Usual Residence of Decedent         10a. State         10b. County         10c. City, Tow           MD         Anne Arunde1         Anna	vn or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	Funeral Director	10e. Street and Number 820 Midship Ct.		10f. Zip Code	21401	10	g. Citizen of What C	ountry?	
	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of F Yes, specify Cub	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+	(Give k life. D	ent's Usual Occup kind of work done O NOT use retire acher	oation during most of work d)	ing 1	6b. Kind of Business  Educati	·	
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		City or Town, State,							
		1 XBunai 2 Cremation 3 Chemoval from State		sition (Name of patory or other pla	: 7/18	/2007	oc. Location - City of		
once.		21. Signature of Funeral Service Linensee	22.	Name and Addre		rdesty Fo	ıneral Hon		
an		23a, Parti. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition						Approximate Interval Between Onset and Death	
al er		resulting in death)  Due to (or as a consequence	of):	This					
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	dical Ex	Due to (or as a consequence							
	ysician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of de Month						
	d by Phy	Part II. Other significant conditions contributing to death but not resulting to	in the un	derlying cause giv	ven in Part I.		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Hrnow		
,	Completed	Decelia				24a. Was an autopsy perform	prior to		
	Be	25. Was case referred to medical examiner?		Ott	ner:	h (Check only one	,		
	ation: To		Time of Injury	28c. Inju Wo		28d. Describe ho	nce 6 □Other (Spewinjury occurred	ecity)	
`	Sertifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, fi building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (Str City or Town,	eet and Number or F , State)	Rural Route Number,	
	Medical Certification:	29a. Certifier (Check only one) Medical Examiner: On the basis of examination a and manner stated.	ge, death and/or inv	estigation, in my	opinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)	
A	1	29b. Signature and title of certifier		29c. Licens	7028	29	d. Date signed (Mon	nn, Day, Year)	
¢.		30. Name and address of person who completed cause of death (Item 23a)	(Type, F	rint)	D 2140	YH CH	10 PRA	19.D.	
Sta istra		31. Date filed (Month, Day, Year)  JUL 1 9 2007  32. Refistrar's Signature	19	book					
4/00	0.4								

Registrar

07-05727

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Randall Desmond F	⊃ick	ens St	ate of Maryla	and / Depa	rtment of	Health	and	Menta	l Hygi			£			
	Da	or State		Cer	tificate of	Death			12	Re Date of Dea	eg. No. th		3. Time of Death		
- Physician/		Decedent's Name (First, Midd								Month July 26, 2	Day 007	Year	0620 hrs		
Mé Examine		Randall Desm	ond Pickens	······································	4	h City To	wn, or Lo	ocation of I			4c. C	County of Dea	ath		
	4a	. Facility Name (if not institution 3188 Route 97	on, give street and in	umber)		Glenwo						ward			
	-	Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under 2		B. Date of Bi	rth(MM/DI	D/YYYY) 9. E	Birthplace (State or eign		
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Director		218-68-3692	1 X M 2 F			1						0.0	10d. Inside City Limits		
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within giene.	Completed by	12 7. Father's Name (First, Midd	le. Last)		<u> </u>		1	18.Mother's	s Name (	First, Middle	, Maiden :	Surname)			
filed filed at Hyg	ည္က က	Hayward F. Pi						Eth	el Ma	e Allen			Out 75 Code		
212 212 ald be Ments mafrk	의	9a. Informant's Name/Relatio	nship (Type, Print )										State, Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is markied other than "natural", or items 23a or 28a-f sho important: A saminer must be notified at once.		Ethel M. Pick	ens - Mother	r	6510 H	avilar	nd Mi	11 Roa	d, C1	arksvil Date	le, M	aryland Location - Cit	ty or Town, State		
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mit. F	4	21. Signature of Funeral Servi	ice Licensee					of Facility  i Fune		ome, Ir	nc.		1 1 2000/		
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hysician		<ol> <li>Part I. Enter the disease, failure. List only one cau</li> </ol>	or mulications that use on each line.	at caused the dea	ith. Do not enter	(No mode	or dyg,						Between Onset and Death		
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ZAGIIIII	- 1	or condition resulting in deali	Due to (or a	as a consequence	5 OI).										
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Box 68760, e death certificate by the attending physic ed for use as the but	Physician/Me	23b. Was decedent pregnant past 12 months?	in the 1 Li	ive birth	2	Fetal death		Ectop	ic pregna	incy	- 0	Month	Day 100.		
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Sior vitend death cror:	cati	2 Accident	Investigation FnC	7/26/200 . Place of Injury -	At home, farm, s	:10 am street, facto	ory, office	e building,	etc.	28f. Locat	ion (Stree	t and Numbe	er or Rural Route Number, City		
Division of Vital Records, pital or Attending Physician: The law requirence and the certificate has been significate has been significate by the funeral director, page 2 should be	ertification:	L. Calcido	determined (Sp.	ecify) Fou	nd: priva	te dwe	lling	3					wood, MD		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buil	Medical	(Check only one) 2 Medica	I Examiner: On the b	pasts of examinat	ion and/or invest	tigation, in	my opin	ion, death	00001100	at the time,					
To the within To the comple	Med	29b. Signature and title of o	and man	ille: Bigled.			29c. Lice	ense numb			29	d. Date signe	ed (Month, Day, rear)		
		M/1.	AN	16			Ο.	C.M.E.			J	uly 27, 20 	U /		
(n)		30. Name and address of p	erson who complete	d cause of death	(Item 23a)					11001					
(14)		Susan Hogan MD		Medical Exam	iner 111 F	Penn Sti	reet, B	altimore	e, MD 2	1201					
		0.10	Vent 1 0007	32. Re strar's Si	ignature .		est.								

Registrar

							artment of H			-	_	ibic.	
			1 - For State Registrar		iai y rai i		rtificate of I		110 111		g. No. 2	107	25120
			Decedent's Name (First, Middle	, Last)			-		T	2. Date of Death	1		3. Time of Death
•	Physici /Medio		Galina A.	Romashk	.0					July 2	7, 200	Year 7	12:57 PM
)	Examir		4a. Facility Name (If not institution,	give street and number	)		4b. City, Town, or	Location of	Death		4c. Count	y of Death	
		91	SHADY GROVE AD  5. Social Security Number		an /In ura	last birthday)	GAITI If Under 1 Year		8. Date of Birth	MONTGOMERY			
	Funeral Director		218-43-8196	1 M 2 X F	76	Yrs.	Months Days	Hours 1	Min.	(Month, Day,	, Day, Year) Country)		
			Usual Residence of Decedent						!	July 2,	1931	RUS	SIA
	arylan show d at	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					1	Od. Inside City Limits
	he Ma 8a-f s	Directo	Maryland Montgo	omery	Gai	thersb							1 X Yes 2 No
	with the		10e. Street and Number				10f. Zip Code			10	g. Citizen of		try?
	eath ns 23	Funeral	530 West Deer I	Park Road 12. Was Decedent	Ever in U	S. 13 V	208		in? (Spe	cify Ves or No.	RUSS:	LA ce - Americ	an Indian
	r iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces	?		Was Decedent of H f Yes, specify Cuba		Puerto F	Rican, etc.)		ck, White,	
ဗ္ဗ	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by	3 X Widowed 4 ☐ Divorced	If Yes, Give 14 Year or Dates:			1⊡Yes 2M∑No	Specify:			Speci	<sup>fy:</sup> Wh	ite
15-0036	72 hc 'natu dical	Completed	15. Decedent' (Specify only highes			16a. Deced	tent's Usual Occup kind of work done o OO NOT use retired	ation during most	of workin	ng 1	6b. Kind of E	Business/Ind	lustry
121	within sne. <b>:han</b> '	ldm	Elementary/Secondary (0-12)	College (1-4or	5+)	l					36 14		
2	filed v Hygie other i		17. Father's Name (First, Middle, L	ast) 5+		l M	edical Do		's Name	(First, Middle, M	Medic		
a	ould be Mentai arked o atic eve	To Be	Alexey G. Roma	,						D. Rom			
Maryland	shoul ind M i mari umati	Ĕ	19a. Informant's Name/Relationsh		-	19b. Mailir	g Address (Street a					, State, Zip	Code)
	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic enone.		Olga Y. Marant	idi/Daughte:	r	530 W	est Deer	park	Rd.	Gaither	sburg.	MD 20	877
Baltimore,	es 1 a of He <b>f Item</b>		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. P	lace of Dispo	sition (Name of matory or other place		D	ate 2	Oc. Location		
Ĕ	Pag ment ant: h ury o		4 Donation 5 Dother (Sp			k Cree			11y 200		lash.,		
<u>8</u>	ermit. epart nport ny Inj nce.		21. Signature of Luneral Service L	censee			. Name and Addres						
_	20 E # 9	100	-alust C	11/100			22 Wiscor					D.C. :	20007
			23a. Part1 Enter the disease, or shock, or heart failure. List	6.7					ardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a			nfarction	ı				2	days
	Examiner		in a sum,	Due to (or as									
	50,00	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Coronary Due to (or as			sease						years
8	uted d ansit	Examiner	cause. Enter Underlying Cause (Lisease or injury) that initiated events										
,097	ate be executed tysician and he burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):							
	ate be hysici the bu	ical		d									
χ 08 Χ	ertific ling pl e as t	Med	IF FEMALE;							_	T		
X R Q	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal	Idéath 3□	Ectopic pregnancy					ate of delive onth	ry Day Year
j	the de	ysic	1 □ Yes 2 <b>X</b> No 9 □ Unknown	4□Pregnant a 9□Unknown	it time of a	eatn 5∟	Other (specify)						,
7	that ned by deta		Part II. Other significant condition	ns contributing to death b	out not resu	ulting in the ur	nderlying cause give	en in Part I.		23e. Did toba	acco use con	tribute to th	e cause of death?
	quires an sign	ed by								1 ☐ Yes	s 2 📉 No	3 ☐ Proba	abiy 4 ∐Unknown
ecord	aw re	Completed								24a. Was an	24b.	Were autop	osy findings available apletion of cause of
ř	The I	mo								autopsy perform 1 Yes 2	ed?	prior to con death? 1 \( \text{Yes} \)	
VItal	ctor,	Bec	25. Was case referred to medical examiner?					26. Place o	of Death	(Check only one			
20	hysik this ca	2	1 ☐ Yes 2 X No			ER/Outpatien		4 🗆 Nurs		ne 5 🗆 Resider			)
	After i	ü	27. Manner of Death 1 X Natural 5 □ Pending		ıry ay Year)	28b. Time of Injury	Work	? /		8d. Describe hov	v injury occu	rred	
VISION	death death stor:	icat	2 Accident investiga 3 Suicide 6 Could no	ot be   290 Place of ini	ury . At ho	me farm etre	M 1□° eet, factory, office	Yes 2 □ No		Of Location (Ctr	nat and Norm	havar Own	David Number
2	after after Direct	Certification:	4 ☐ Homicide determin	building, et			set, factory, office			8f. Location (Stre City or Town,	State)	per or Hurai	Houte Number,
	spita lours neral / filled		29a. Certifier 1 Certifying	Physician: To the best	of my kno	wledge, death	occurred at the tin	ne, date and	place, a	and due to the ca	use(s) and m	anner as st	ated.
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st	ot examina	tion and/or inv	estigation, in my o	pinion, death	n occurre	ed at the time, da	te and place,	, and due to	the cause(s)
	To the within To the Comp.	M	29b. Signature and title of certifier		1		29c. License	number		29	d. Date signe	ed (Month, L	Day, Year)
ł			1 / of the	1 de	Us.	171	03	332	.61	Ju	1y 27,	2007	
	1		30. Name and address of person w			, , , , ,	,	117	1	00055			
	,		William Dooley 9	100 B i-4				ille,	MD	20850			
	Sta Registr	-	AUG 0 6 20	32. Registr	ar s Signa	Coarl							
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To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

24 hours after death • Funeral Director:

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatur e and title of certifier 29c. License number D58391

29d. Date signed (Month, Day, Year) July 30, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sajjed Aziz, M.D., 801 Tollhouse Avenue, C-3, Frederick, Maryland 21701-4555

Registrar

Medical

To the

**Physician** /Medical Examiner by Physician/Medical Examiner

**Physician** 

/Medical

Examiner

MD

Director

Funeral

Completed by

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

of Health a

permit. Pages 1
Department of I
Important: If Ite
any Injury or ot

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

been signed by the attending physician and should be detached for use as the burial-transit has filled in by the funeral After

Be Completed

Certification: To

Medical

or Attending Physician: The law requires that the death certificate be executed

this

24 hours after death Puneral Director:

completely within 2

Division or Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pr
in the past 12 mg
1 ☐ Yes 2 ☑
9 Unknown

Was case referre	ed to medical		26. Place of Death (Check only one)											
examiner? 1 ☐ Yes 2 ☐ 🗡	ro [	Hospital: 1 ☐ Inpatient	2 🗆	2 ☐ ER/Outpatient		DOA	Other: 4 Nursing H		ome 5 Residence 6 Other (Specify)					
Manne of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		ear)	28b. Time of Injury	М		Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury building, etc. (	- At ho Specify	ome, farm, stree	t, facto	ory, of	fice		28f. Location (Street and Number or Rural Route Numb City or Town, State)					

29a.	Certifier
	(Check on

27 M

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Cynthia Kutther Sands, mil 29c. License number

29d. Date signed (Month, Day, Year) July 24, 2007

Synthia Kuttner-Sands up 16505 Virginia Avenue, Williamsport, Maryland

State Registrar

Q2H-4

31. Date filed (Month, Day, Year)



			For	t <b>pe or Print in B</b> State of Maryland	d / Depa	artment of H	lealth and l		•	25123		
			State Registrar		Cei	rtificate of	Death		g. No.			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Alice C. Ray			45 City Target	al acation of Docti	1-7	Day Yeer 200-	7 01 :25 AM		
	Examin	er	4a. Facility Name (If not institution, give str 1 Cecil Manor D			Warwic	r Location of Deat K	1		County		
Ī	Funeral Director		134-03-0090	7. Age (In yrs. ia 86	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			inthplace (State or Foreign Country) wnsend, DE		
Par Par Par	-f show	tor	Usuel Residence of Decedent  10a. State 10b. County  MD Cecil		Town or Lo	_				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
di dina	23a or 28a	al Direc	10e. Street and Number 1 Cecil Manor D	rive		10f. Zip Code 2191	2	10	10g. Citizen of What Country? U.S.A.			
OU36	ous arier death with his marylan rel', or Items 23a or 28a-f show Exercit et mast be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes → XNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: W			
1215-0035	ne. hen *naturel', e Medical Exe	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usuel Occup kind of work done DO NOT use retired	during most of wor	rking	6b. Kind of Busines			
ב ביינו	ental Hygi ked other Ic event, I	To Be Co	11 17. Father's Name (First, Middle, Last) Kenneth Watts			Caregi	18. Mother's Nar Nora					
Mary	thealth and Men tem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type Joan E. Ray/Dau			•			•	v or Town, State, Zip Code)		
<b>a</b> .	of Health item 27 other to		20a. Method of Disposition	Date 2	20c. Location - City or Town, Stete							
Baltimore,	Definit. Fages Department of h Important: If its any injury or of		¹XP8urial 2 ☐ Cremation 3 ☐ Rei ¹ 4 ☐ Donation 5 ☐ Other (Specify)  2↑Signature of Funeral Service Licensee	4/2007								
Ra	Depa Impo any ii		- Dunad	ra Russ	D 2	ANIELS 12 N. B	& HUTCH road St	ISON FUI	NERAL HO	ME LLC DE 19709		
	hysician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) a.	itions that caused the death cause on each line.	Do not ent	er the mode of dyir	ident	or respiratory arre	st,	Approximate Interval Between Onset and Death 25 mon 145		
<b>60</b> ,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cene babyasscular avtento scleros is Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
O. Box 687	e atter	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☒ No 9 □ Unknown	c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnent at time of de 9□Unknown	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year			
rds, P.O	n signed by t	۵	Part II. Other significant conditions control  Cononany not	ibuting to death but not resu	•	, , ,	en in Part I.			to the cause of death?  Probably 4 Monknown		
ř	tate has been signification	Completed	/					24a. Was an autopsy perform 1 Yes 2	ed? prior to			
Vital	certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:		at 20 DOA Oth		ath (Check only one				
ō	After this funeral dii	ıtlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1   Inpatient 2   E	ER/Outpatier 28b. Time o Injury	f 28c. Injui	y at	dome 52 Resider 28d. Describe how		ecify)		
DIVISION	s after death. Il Director: After	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,		
1	within 24 hours after to the Funeral Directory to the Funeral Directory of the Funeral Directory of the filled in	edical (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exemine	cian: To the best of my known: On the basis of examination and manner stated.	vledge, death ion and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)		
5	within To the	Me	29b. Signature and title of certifier	, -		29c. Licens			d. Date signed (Mo			
			· Wollens	an mh			73577			0,2007		
CF	1 (	6	30. Name and address of person who com W. Bruce Ob	enshair,	23a) (Type,	Cec	Silfon	md 21	213-00	670		
6.	Sta Regista	ite	31. Date filed (Month, Day, Year)			for the						

P.O. Box 68760 attending physician signed by the a Records. certificate Division or Vital this funeral

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** amar 3330 M 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** pastal Hospice at the Wicomica alisburg 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months 1 → M 2 □ F 81 219-22-2589 Director 3/28/1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show at permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. 1 □XYes 2 □ No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 1105 S. Schumaker Dr., Apt. 308 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. l ∏Yes 2**X** No f Yes, Give ∕ear or Dates: 1 ☐ Never Married 2 ☑ Married white Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) certified optician eye care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Sinclair James Edward Rambo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 S. Schumaker Dr., Apt. 308, Salisbury, MD 21804 Martha N. Rambo/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/24/07 Salisbury Crematory Salisbury, MD <sup>22. Name and Address of Facility</sup>
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Lica Well K Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HBIMERS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi CONGRITIUR Due to (or as a consequence of) Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy perforn 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARUS HOSPICE 10130x #1723 COASTAL GHUMM 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Please	Type or Prir							-	ible.		
			For State		State of Ma	aryland		epartment d C <i>ertificate</i>			ental Hyg	giene			
			Registrar  1. Decedent's Name	/Eiret Middle Is	net)			Jeruncate	or Dea		. Date of Dea	Reg. No.		3. Time of Death	
Phy	/sicia	ın	Cal.	First, Middle, La		Da	(0:0	- 10			Month	Day	Year	3. Time of Death	
	ledic	_	4a Facility Name //	not institution, all	ve street and number)	Ne	X) (	4b. City, Tov	n or Locati	ion of Death	/	4c. Count	v of Death	0733 "	_
Exa	amin	er	MICH	Laco	100 01	1101	ak	0	5,1:	5 hin	Λ	11)	•	nico	
Fune	eral	-3	5. Social Security N		Sex 7. Ag	e (In yrs. la	st birth			ider 24 Hrs. 8	Date of Birth	1 (())	9. Birth	place (State or Foreign	_
Direc		ŀ	217-42-5		1 □ M 2 🛣 F	65	Υ	rs. Months D	ays Hou	1	(Month, Day 3/4/194			intry) W York	
pu »			Usual Residence of 10a. State	Decedent 10b. County		100 City	Tours	or Location			-, -,				
laryla shov	ta da	5	_			,	aure							10d. Inside City Limits 1 ☐ Yes 2 🕱 No	
the N	ot li	Directo	Delaware  10e. Street and Nur	Susse	X.	با	aure	10f. Zip Co	do		10g. Citizen of What Co			intry?	_
with	i pe	اق		Al-Jan Di	civo				956			USA		andy:	
IN ELE 13-0030  If lied within 72 hours after death with the Maryland Hygiene.  ther than "natural", or items 23a or 28a-f show	mus	Funeral	11. Marital Status	AI-Oall D	12. Was Decedent	Ever in U.S									_
after o	niner		1 ☐ Never Marri	ed 2 Married	Armed Forces?	No					can, etc.)		ick, White		
ral", o	Exan	þ	3 🗌 Widowed	4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀	No Spe	city:		Specia	y:	white	
72 h	dica	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Indus			
han.	ě M e	d m	Elementary/Seco		College (1-4or 5	5+)			etired)	J		, ,			
led v Hygie	티		12 17. Father's Name (	First Middle Las	4		nı	ırse	18 M	other's Name (	First Middle		th c	are	_
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2 should be and Mental	Hati	ည	19a. Informant's Na		(Type, Print)		19b.	Mailing Address (S				r City or Town	State 7	in Code)	_
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partitions, interpretable 2.12.13.1000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 28a or 28a-f show	any inju	ŀ	21. Signature of Fu	neral Service Lice	nsee	<del>Gar</del>	den	22. Name and A	ddress of F	acility Ho	mo Pro			ssociation	_
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Physic			Immediate Cause ( disease or condition	Final n	METAS	TAT	ic	BRBA	ST	GARC	iNO	MA		Onset and Death	
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Atten deatl ctor:	y me	ica E	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e 28e. Place of inju	ury - At hor	ne, farn	n, street, factory, of			f. Location (S	treet and Num	ber or Rui	ral Route Number.	
after Dire		Certification:	4 ☐ Homicide	determined	building, etc	c. (Specify,	)				City or Tow				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and managed that it is to the former death.	eny mile		29a. Certifier (Check only	CertifyIng Pi	hysician: To the best of miner: On the basis of	of my knov f examinati	ledge, on and	death occurred at t	ne time, dat my opinion.	e and place, an	d due to the o	cause(s) and m	anner as	stated.	
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36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status	ow Hill R ried 2□ Married 4□ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	?		21864 Was Decedent of I If Yes, specify Cub 1□ Yes 2☑ No		? (Specify Yes or uerto Rican, etc.	No-	USA  14. Race - Ame Black, White Specify: Wh	e, etc.
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ē,	permit. Pages 1 and 2 Department of Health s Important; If item 27 Is any injury or other tra once.		20a. Method of Dis		daughter	,	ace of Dispo	Snow Hi esition (Name of matory or other pla	ice)	Date	20c.	Location - City or	
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D	1.5			ress of person who	SATYAL	14 0	1601	MARKE	T ST 1	Pocomoic	e C	TY MD	21851.
19	Sta Regist	ate rar	31. Date filed (Mo	nth, Day, Year)  JUL 2 3 2	007 32. Fegist	trar's Signat	ture	rede					

DHMH 17 Rev 1/2001

		1	State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygie <sub>Reg.</sub>	0000	25127
П			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day 2007 Year	3. Time of Death
	Physicia /Medic	_	Lauren Marie Roeser		July 23,		3:37 PM
)	Examin		4a. Facility Name (If not institution, give street and number) Kline Hospice House	4b. City, Town, or Location of Death Mt. Airy		4c. County of Deat	t
Ē	Funeral Director		5. Social Security Number  032-46-2819  6. Sex 1 M 2 XF  7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye Mar 28, 1	9. Birt Co .955 Mass	hplace (State or Foreign untry) sachusetts
	р		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Low           MD         Washington         Knoxville	ocation			10d. Inside City Limits 1 □ Yes 2 ☒No
	r 28a- notif	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Co	untry?
	h with 23a o st be		2165 Reed Road	21758	US		
တ္ဆ	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	F.	1 □ Never Married 2 Married 1 □ Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
5-003	72 hours 'natural', dical Exa	eted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Dece	dent's Usual Occupation  kind of work done during most of work DO NOT use retired)	ding	b. Kind of Business/	
2121	ed within /giene. er than " t, the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher	er	1	lucation	
nd	be file	Be	17. Father's Name (First, Middle, Last) Henry Albert Johnson		rances Dr	,	
Maryland 21215-0036	12 should th and Mer 7 is marke traumatic	은	19a, Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Run Reed Road Knoxvil	ral Route Number, C	City or Town, State, a	Zip Code)
lore,	Pages 1 and nent of Healt int: If item 2: iry or other		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Oceanee	2. Name and Address of Facility oing Home Crematic everly L. Heckrott	n Service	P.O. Bo	ox 784
8760,	Medical Examiner  bh/sician and sthe pnual-transit	al Examiner	Due to (or as a consequence of):    Comparison of the construction				
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Δ.	uires that the de signed by the a d be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 ☐ Yes		o the cause of death? Probably 4 □Unknown
al Records,	The law ate has b page 2 s	Completed			24a. Was an autopsy perform	prior to death? No 1 ☐ Ye	
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 L ritifying Physician: To the best of my knowledge, dea  2 Medical Examiner: On the basis of examination and/or  and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred 29c. License number	urred at the time, da	te and place, and di	ue to the cause(s)
	.3	2	29b. Signature and title of certifier	D3518	-3 (	Veles 24	2007
r	10EG.		30. Name and address there is n who completed cause of death (Item 23a) (Type	e, Print) Do West go	th 5/4/	eder	ch mi
	St Regis	ate rer	31/ white filed (Month, Day, Year) 32. 32. Signature	Sec. 11.			

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 1<sup>Day</sup> **Physician** 2007 Jennifer Ann Reed 2:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 908 Berwick Drive Anne Arundel Annapolis Annapolls
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1□M 2∏F **Funeral** Days Months 1948 California 59 Director 569-86-5599 April 7 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extender must be notified at 1 √X Yes 2 □ No Marvland Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 908 Berwick Drive United States within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 1 Never Married XX Married 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Interviewer Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H I Item 27 Is marked oth Be Don Pullen Frances Buford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Reed / Husband 908 Berwick Drive Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of F permit. Pages Department of Important: If It any Injury or or Baltimore Crematory 7/18/2007 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 6/1acho 147 Duke of Gloucester St. Annapolis. MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (TUOBLASTIMA trusust **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or se a consequence of) Examine executed burial-transit and Due to (or as a consequence of): ng physician as the burial Division or Vital Records. P.O. Box 68760. certificate be Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an performed? res 2/2/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. i or Attend after death Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 29a, Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely one) and manner stated.

USA

2

State Registrar 29b. Signatu

30. Name

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at Baltimore, Maryland 21215-0036 "natural" Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any injury or other traumatic event, the Aone.

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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ompleted

**Funeral** 

**Director** 

**Physician** /Medical Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Division or Vital Records, P.O. Box 68760,

Bec	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Maide	en Surname)		
To B	Moses Joseph	Salid		Din	ah Slutzky			
	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing Address	(Street and Number or R	Bural Route Number, City	or Town, State, Zip Code)		
	Martha T. Wolpert	- Daughter	4992 Swir	ton Drive,	Fairfax VA	22032		
	20a. Method of Disposition		Place of Disposition (Nan emetery, crematory or o	ne of ther place)	Date 20c.	Location - City or Town, State		
	11 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	removal from State	th David Ce	metery 07/	22/07 Elm	ont, New York		
	21. Signature of Funeral Service Licens	200				i Funeral Home, In ver Spring, MD 209		
	23a. Part1 er the disease, or compl shock, or heart failure. List only or	cations that caused the deatl				Approximate Interval Between		
	Immediate Cause (Final disease or condition	ARTERI	AL HYP	ERTENSI	ON	Onset and Death		
	resulting in death)	Due to (or as a consequ	uence of):				_	
	Sequentially list conditions	CARDIA	7C HK	RYTHM	117			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
imi	that initiated events							
EX	resulting in death) Last	Due to (or as a consequ	uence of):					
ca		1.						
ledi							_	
n/N	IF FEMALE: 23b. Was decedent pregnant	23d. Date of delivery						
Be Completed by Physician/Medical Examiner	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown				Month Day Year	Day Year	
P	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying c	ause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
ed by	SENILE DE	FHENTIA	7			2 No 3 Probably 4 Unknown		
plete					24a. Was an	24b. Were autopsy findings available prior to completion of cause of	)	
Com					autopsy performed? 1∐ Yes 2 ☐	death?		
Be	25. Was case referred to medical examiner?				eath (Check only one)			
	1 ☐ Yes 2007No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DC	A Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐Other (Specify)		
tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 2 Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred		
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, factory	, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, te)		
Medical Certification: To	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and plac in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)	-	
Me	29b. Signature and title of contifier  Bullanue	Celien	yKD.	D 35436	5 Ju	late signed (Month, Day, Year)		
	30. Name and address of person who co	impleted cause of death whem	6 ZIPLOV	TROSERON	7D, ROCKV	ILCE, MD 20852	2	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

23

2007

egistrar's Signature

07-05736 UNK UNK

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 23130

NIC OINIC		- For State Certificate of	Death	Reg. N	No		
Physicia		egistrar I. Decedent's Name (First, Middle,Last)		<ol><li>Date of Death Month Da</li></ol>	y Year	3. Time of Death 2308 hrs	
r Exami	ner	Nirina Razanadahy		Month Da July 25, 2007	4c. County of Deat	<u> </u>	
	1	4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Death Olney		Montgomery		
		Montgomery General Hospital		8 Date of Birth/s	Birth(MM/DD/YYYY) 9. Birthplace (State or		
Funeral	,	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min		Fore	ign I	
Director	- 1	577-04-0978 1 M 2XF 38 Yrs		May 12,	1969	<sup>ountry)</sup> Ethiopia	
		Usual Residence of Decedent	on.			10d. Inside City Limits	
, any		10a. State 10b. County 10c. City, Town or Locat	OII			1 Yes 2 No	
and show	5	VA Alexand	ria	100	Citizen of What Co	21	
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code 22311			,	
the la or stiffe		5021 Seminary Rd. #512		Ethiopia	erican Indian, Black,		
with	eral	II. Marital Status	as Decedent of Hispanic Origin? ( S 'es, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	erican indian, black,	
death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	Never Married 2 Married 1 Yes 2 X No	Yes 2 X No specify:	104	Specify: B1	ack	
after al", c	à.	3 Wildowed 4 - Bivolded or Dates:	work done	6b. Kind of Busines:			
5-0036 ed within 72 hours after dygiene. other than "natural", the Medical Examiner		during m	nt's Usual Occupation (Give kind of nost of working life. DO NOT use rel				
6 n 72 l	Completed	College (1-4 or 5+)   2   Make-	up Artist	- 1	Cosmetolo	gv	
within jene.	Ē,	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Mai		<u> </u>	
15-1 filed I Hyg et otl			Yeshi	Tesl	.*		
21215-0036 hald be filed within 7 Mental Hygiene. marked other than	To Be	Raymond Razanadahy  19a. Informant's Name/Relationship (Type, Print )  19b. Mailin	g Address (Street and Number or	Rural Route Number	er, City or Town, Sta	ate, Zip Code)	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show on other traumatic event, the Medical Examiner must be notified at once	-	Yeshi Teshome/Mother 5021	Seminary Rd. 512	, Alexand	iria, VA	22311	
e, MD 2 and 2 shou Health and I item 27 is r		20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date	20c. Location - City	or Town, State	
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		1 X Burial 2 Cremation 3 X Removal from State Fairfax 1 4 Donation 5 Other Specify:	Memorial   0/	2/2007	Fairfax.	Virginia	
Saltimo Permit. Pag Department Important:	$\lambda$	4 Donation 5 Other Specify: Park 21. Signature of Funeral Service Licensee	Name and Address of Facility irfax Memorial I	2/200/	rairiax	V.1.51111	
Baltimore, MD opernit. Pages 1 and 2 shoot Department of Health and Important: If item 27 is injury or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other transmatinium or other or other transmatinium or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other or other		Fa 201508	irfax Memorial b	funeral Ho Fairfax	ome . VA 220	32	
hysician		Breun M 72 M01508 99  23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and	
/ledical		failure. List only one cause on each line. Complications of coal Immediate Cause (Final disease a. granulomatous disease of	agulopatny associated	with fore	ign body	Death	
≟xaminer		or condition resulting in death)  a. Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities as Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authorities and Statistical authoritie	THE THIS				
		Sequentially list conditions, b.					
	ner	if any, leading to immediate cause. Enter Underlying Cause					
	Examin	(Disease or injury that initiated					
ted I Insit	Ĕ	events resulting in death) Last Due to (or as a consequence or).					
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	dical	X UNPENDED AMENDED DTT 27 porME 9972	10 // /07 mm				
60, ate be	Med	IF FEMALE:  AMENDED #23a.PII.27.perMF.g872			23d. Date of deli	•	
Sox 68760, death certificate be re attending physicil of for use as the buri	Ę	23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic preg	nancy	Month	Day Year	
Box 687 e death certific the attending ped for use as the	👸	4 Pregnant at time of death 5	Other (Specify)				
Bo le dea the a	Physician/	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tok	pacco use contribute	e to the cause of death?	
P.O. es that the signed by be detach	=	li .	s and onlying cause govern	1 Yes	2 No 3	Probably 4 🗸 Unknown	
S, P.  irres 1  irres 1  de ber 4	Completed by	Clinical history of cervical cancer		24a. Was a	n 24b. Wer	e autopsy findings available	
ord: w requisible	let			autops perforr			
ec( he lar ate ha	6			1 ✓ Yes 2	2 No 1 ✔	Yes 2 No	
Division of Vital Records, P.O. B rate of Attending Physician: The law requires that the d rs after death.  The The The The The Corrificate has been signed by the law in by the fineral director, name 2 should be detected lad in by the fineral director, name 2 should be detected.	Be	25. Was case referred to medical	26.Place of Death (Che				
Vita hysicia this ce	10	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie				Other:	
Jof V Jing Phy After tl funeral	<u>-</u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of		28d. Describe n	ow injury occurred		
On sath.	텵	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			- Dural Pouta Number Cit	
/iSi r Att ter de irect	122	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (S or Town, St		r Rural Route Number, Cit	
Divisial of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straight of straig	Certification:	4 Homicide determined (Specify)					
Hosp 24 ho Func			curred at the time, date and place,	and due to the cause	e(s) and manner as and place, and due	stated. to the cause(s)	
Division of Vital Records, P.O. E To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Pannaral Director. After this certificate has been signed by the conventency filled in by the finneral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	29c. License number		29d. Date signed	(Month, Day, Year)	
T S F S	`  <b>≚</b>				July 27, 2007		
		Donna mu incerti, M.D.	O.C.M.E.		July 21, 2001		
ı		30. Name and address of person who completed cause of death (Item 23a)		MD 04004			
		Borna W. Vinesna, W.	11 Penn Street, Baltimore	, IVID 21201			
	State	31. Date filed (Month Day Year) 1 2007 32. Reparar's Signature	1 -				
Reg	istra		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s				
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		•	For Stata Registrar	State of Maryla		artment of H		Ť	giene Reg. No.	17	25	13
			Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of	Death
П	Physici: /Medic		Gras	on Ray Stubb	s, Jr.			July	27 20	07	2124	Рм
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of	Death	4c. County of			
			453 Booth Street			E1kton	I I Indos O	4 Hear I a la  Ceci			-	
	Funeral Director		5. Social Security Number 6. Sex 1 🗓	M 2□ F 7. Age (In yrs	. last birthday) Yrs.	Months Days	If Under 2 Hours	Min. 8. Date of Bird (Month, Da MAR 19,	v, Year)	Coun	lace (State of stry) v land	r Foreign
			Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·				IIII 17,	1/34			
	how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside Ci 1 1 Yes	
	8a-f e	Directo	Maryland Cecil		E1kton							2 1110
	with the page 2 page 2		10e. Street and Number			10f. Zip Code			10g. Citizen of W		,	
	eath	erai	453 Booth Street  11. Marital Status	2. Was Decedent Ever in	U.S. 13	21921	ispanic Orig	in? (Specify Yes or No	Unite		artes	
	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or items 23a or 28a-f ehow ent, the Medical Examiner must be mutified at	Funerai	1 Never Married 2 Married	Amed Forces? 195	2-	If Yes, specify Cuba	n, Mexican,	Puerto Rican, etc.)	Black	, White,		
ğ	ral', o	þ	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give 195 Year or Dates:	66	1 ☐ Yes 2 🔀 No	Specify:		Specify:	Whi	.te	
2	72 hc 'natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa	durina most	of working	16b. Kind of Bus	siness/Ind	dustry	
2	within	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Coc	DO NOT use retired	0		Resta	uron	+	
7 0	Hygie ther i		17. Father's Name (First, Middle, Last)	3	C00	)K	18. Mother	's Name (First, Middle			L	
<u>a</u>	td be ental ked o	To Be	Grason R. Stubbs	. Sr.			Mai	ry Rebecca	Meehan			
ary	shou ind M mar	۲	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street		or Rural Route Numb		State, Zip	Code)	
Ξ	and 2 laith a 127 i. er tra		Rebecca J. Yates	/Daughter	29 H	ollingswo		anor, Elkto				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Re	1	Place of Dispo cemetery, crea	osition (Name of matory or other place	e) .	July 28,	West (	City or To Chest	own, State	
Ĕ	Pag ment ant:	Н	4 □ Donation 5 □ Other (Specify)	R.A		s & Co., Inc	. [ ]	2007	Pennsy	1var	nia	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multified at once.		21. Signature of Funeral Service License	Lieber	H <sup>2</sup>	2. Name and Addres LCKS Home )3 W. Stoo	ss of Facility for F ckton	unerals, P Street, El	.A. kton, Ma	ry1a	nd 219	921
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e cause on each line.  Tue to (or as a conse	equence of :	P)	exolo Exolo	cer but	21)		Approximat Interval Bet Onset and	ween
68760, 2	rificate be executed ng physicien end as the burial-transit	Aedical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:	Due to (or as a conse	equence of):							
.O. Box	The law requires thet the death certifice ate has been signed by the attending prpage 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of preging the properties of the pregnant at time of p Unknown	tal déath 3[	□Ectopic pregnancy □ Other (specify)			23d. Date Mon		,	Year
Division of Vital Records, P.	quires the n signed uld be del	þ	Part II. Other significant conditions conf	tributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.		tobacco use contri Ýes 2□No	ibute to th 3 ☐ Prob		death? Unknown
ပ္က	aw requir is been si 2 should l	Completed	Chronic Ro	nal fails	1st			24a. Was	an 24b. W	Vere auto	psy findings mpletion of c	available
ž	Physician: The lavithis certificate has al director, page 2	Com	Ders Mercal	rascula	Dis	CKP.		perfo	ormed?   d	eath?		2030 01
ā	sian: artifica ctor, I	Be C	25. Way case referred to medical examiner?					of Death (Check only	one)			
<u>&gt;</u>	hysic his ce al dire	To	1 ☐ Yes 2 No	<del>,</del>	☐ ER/Outpatie			sing Home 5 Resi			ý)	
ב	ling P	lon:	27. Manner of Death 1, Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	yat k? Yes 2.∐N		how injury occurre	9d		
<u>s</u>	or Attending Physician: after death. Director: After this certifics in by the funeral director, I	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st		163 201		Street and Number	er or Aura	al Route Nun	n <i>ber</i> ,
≧	after after Directory	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)			City or To	wn, State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 CC Certifying Phys (Check only one) Medical Examin	ician: To the best of my kner; On the basis of examination and manner stated.	nowledge, deat nation and/or in	h occurred at the tir evestigation, in my o	ne, date and pinion, deat	place, and due to the h occurred at the time,	cause(s) and man date and place, a	nner as s and due to	tated. the cause(	s)
	To the Ho within 24   To the Fu	Me	29b. Signature and fille of dennier	11111		29c. Licens	e number		29d. Date signed	(Month,	Day, Year)	
1			<b>*</b> ////////////////////////////////////			DYS	155		07/31	1/2	200	
	rxl		30. Name and address of person who con				·_/			1		
	Э,		John R. Mulvey, M.			., Suite	309, I	Elkton, MD	21921			
	Sta Registr		31. Date filed (Month, Day, Year)	a2. Registrar's Sig	nature	els. 9						

# 3altimore, Maryland 21215-0036

**Physician** /Medical Examiner and attending physician for use as the buria

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician FRANCES STINE JULY 27 2007 7:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Days Hours Min Months 1 □ M 28 □ F MD 11/25/1910 Director 220-40-0078 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Director Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21702 1715 West Seventh Street Apt 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【No Specify 2 3 Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche Stitely Charles Warner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14661 Peddicord Rd Mt. Airy, MD 21771 Richard H. Stine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/31/2007 Mt. Airy, Maryland 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility Keeney & Basford P.A. F.H MO1176 | 106 East Church St. Frederick, MD 21701 Xkan 3a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreumonia )A95 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Dempatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 026499 7-28-07 Ronald E. Miller M.D. 4 Culwell
Ronald E. Miller M.D. 4 Culwell
Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 4 Culwell Drive Mt. Airy, MD 21771 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** , 200<sup>re</sup> July Inez Smith 25 0015 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. 239-40-2933 78 NC Director Oct.17,1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1 Yes 2 No must be notifled Director PG Capitol Heights Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō 708 Iona Terrace 23a United States 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ō 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Archives Technician Fed. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental I Richard Thomas 2 Florence Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 708 Iona Terrace Capitol Heights, A.D. Smith/husband Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of H Important: If Ite any injury or of 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/31/07 Md. Veterans Cem. Cheltenham, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Paft / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Ovarian Cancer /Medical Due to (or as a consequence of): Acute Renal Failure Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Ascites g physician and as the burial-tran Due to (or as a consequence of): Physician/Medical Coagulopathy IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy certificate 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 [X]npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No P 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death Injury

Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. To the Hospital within 24 hours a To the Funeral L

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

After thi Certification: 5 ☐ Pending investigation (Month, Day Year) 1 XNatural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D55148 July 25, 2007

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

Forest Glen Road, Silver Spring, Md. 20910 Ang√in, 1500 Delroy 31. Date filed (Month, Day, Year) 2007 AUG 0 3

State

Registrar

			For State Registrar	State	of Marylar		artment of F tificate of				iene	1	25134
	22		Decedent's Name (First, Middle	, Last)						2. Date of Deat			3. Time of Death
	Physicia		Daniel Wilbur S	Sexton, S	r.					July	19 200	or 7	5:10 PM
ļ	/Medic	_	4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, o	or Location	of Death		4c. County of E	Death	
		, a	1085 Rock Sprin	igs Road			Cor	nowing	go		Cecil		
	Funeral			6. Sex 1 X M 2 □ F	7. Age (In yrs.		ff Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day,	Year)	Birthpla	ice (State or Foreign
	Director		218-40-1880	11 <u>A</u> M 2 <u>L</u> F	6.	3 Yrs.				Aug. 13	3, 1943		ryland
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					100	d. fnside City Limits
	Aaryli I eho	ō	v 1 1 0	. ! 1									1 ☐ Yes 2 📉 No
	28a-f	Director	Maryland Ce	cil		U	nowingo		_	11	0g. Citizen of Wha	t Countr	v?
	with Be or		1085 Rock Sprin	on Pond			219	18			USA		,
	ne 23	Funerai	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13. 1	Was Decedent of I		rigin? (Spe	cify Yes or No-	14. Race -	America	n Indian,
0	r Iter	필	1 ☐ Never Married 2 ☐ Marri	ed 1 XYes	2 🗆 No					lican, etc.)		White, et	tc.
3	hours after death with the Maryland ture!', or Iteme 23e or 28e-f ehow at Extrainer must be notified at	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, G Year or	Dates: Viet:	nam	1 □ Yes 2 🔀 No	Specify	··		Specify:	Wh:	ite
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7	within 72 ene. then "nai	npie	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	kind of work done DO NOT use retire	d)				_	
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ă D	be fill bd ott	Be	17. Father's Name (First, Middle, I								valgen Sumame)		
Maryland 21215-0036	should be nd Mental marked o	P	Elijah Thomas S			10h Mailie	a Address /Ctrass		sie Pe		City or Town, Sta	to Zin (	Code)
<u>a</u>	d 2 st th and 7 te r				m d o m		Crocus Co				•	110, ZIP C	2000)
	es 1 and 2 should to Health and Ment fitem 27 le markedr rother traumatic e		Daughter, Shanr 20a. Method of Disposition	ian Alexa	20b. F	Place of Dispo	sition (Name of				20c. Location - Cit	y or Tow	n, State
و	Pages nent of int: If it		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State		matory or other pla		7-24	-2007	Danlinat		Maryland
Baltimore,			21. Signature of Funeral Service I		Da	22	on Cemete	ess of Facil	lity			-0119	Maryland
ñ	Departr Departr Importu any inju		Laboral	9 (1.	a lie	1	R. T. Foa	ard Fu	unera	l Home,	P.A. Sun, MD 2	2101	1
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	Physician		fmmediate Cause (Final	only one cause on		en		10					Onset and Death
1	/Medical		disease or condition resulting in death)	a	o (or as a consec		Coco	10					
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ŠŪ,	cate be executed physician and the burial-transit		resulting in death) Last	Due to	o (or as a consec	quence of):							
8760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d									
×	leath certific attending p	by Physician/Me	IF FEMALE:	23c. ff ves. o	utcome of pregn	ancv					23d. Date o	f deliver	
Rox	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	aldeath 3[	Ectopic pregnance Other (specify)	У			Month		y Day Year
o.	at the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk		304.11	_ (speen)/ _						
<u> </u>	res that igned by be deta	F Y	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause gr	ven in Part	I.	23e. Did tot	oacco use contribu	ite to the	cause of death?
Records,	puires n sign	d b								1 □ Y€	es 2 □ No 3 (	☐ Probai	bly 4 Dunknown
Ö	w require s been sign	Completed								24a. Was a		re autop	sy findings available
	hysicien: The law his certificate has t I director, page 2 s	E							-	autops	ned? dea	r to comulth? Yes 2	pletion of cause of
Vital		0	25. Was case referred to medical					26. Pfac	e of Death	(Check only on		103 2	
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<u>ত</u>	r Attending P er death. rector: After t by the funera	atlc	2 ☐ Accident investig	gation				Yes 2	]No				
Division of	ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	innd 200. Flat	ce of Injury - At h ding, etc. (Speci	nome, farm, str	eet, factory, office		2	18f. Location (St City or Town	treet and Number n, State)	or Rurai .	Route Number,
	urs af												
	Hosp 24 ho Fune fely fi	ica	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the	basis of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date a opinion, de	ath occurre	and due to the ca ad at the time, d	ause(s) and mann ate and place, and	er as sta	ited. the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29b. Signature and title-of-certifier		inner stated.		29c. Licen	se number		2	9d. Date signed (/	Month,}D	Pay, Year)
)	F 3 F 8	İ	1/5/			:KA	( ) Ds	105	36111	19	7/2	3/9	7
•	11.		30 Name and address of person	who completed on	use of death (Ita	m 23a) (Tunh	Print)	100	1		1100	-10	
	4+1VA		// /	nson M	D 111	Noat	Hoals 5	1.5	into	302 7	ElHon	MD	21921
10	s <sup>2ac</sup> Sta	ite	31. Date filed (Month, Day, Year)	<b>1</b> 32.	Registrar's Sign	ature	- Ingri		-,		1		10-1
- 2	Registr		JUL 2 4 20	07 Blue	a S.	Good							

			1 - For State Registrar	State of Ma	aryland / De	partmen ertificat			nd Mer		iene 007	25135
	•	ia.e	1. Decedent's Name (First, Middle, Last)			••			2.	Date of Death	n Day Yea	3. Time of Death
	Physici /Medic		Shirley Fern Ster	n							22, 2007	11:33 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location of	f Death		4c. County of De	ath
			415 I Street					ke Pa			Garrett	
8.	Funeral Director		5. Social Security Number 6. Sex 212-24-6954  Usual Residence of Decedent	M 2XIF	e (In yrs. last birthdi Yrs	Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, an. 16	9. B 1929 M	irthplace (State or Foreign Country) aryland
	land ow	}	10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
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	h the	Director	10e. Street and Number		110111	10f. Zip				10	og. Citizen of What	Country?
	th wit	alD	415 I Street			2	1550	)			United S	tates
	ams	by Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 1	3. Was Deced	dent of H	ispanic Orig in, Mexican,	in? (Specify Puerto Ric	Yes or No- an, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	or It	y FL	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 <b>X</b> 1 If Yes, Give	lo	1 🗆 Yes		Specify:			Specify:	_
Ö	hour tural	q pa	15. Decedent's Educ	Year or Dates:	16a De	cedent's Usua	al Occup	ation			16b. Kind of Busines	nite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-1 show Ita Madical Evarinet mast be rodified at	Completed	(Specify only highest grade	completed)	(G	ive kind of wo	rk done o	during most	of working		TOD. TAITO OF DUONTO.	a modelly
7	y with	mo mo	Elementary/Secondary (0-12)	College (1-4or 5		memake	r				Own Home	
פ	e filed al Hygie other vent. II	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F.	irst, Middle, N	Maiden Surname)	
Maryland	uid b Ments arkad	To E	William Stonesife	er				Mab	el My	ers		
lar)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event. It a Medical Examination and Once.		19a. Informant's Name/Relationship (Type	oe, Print)			•				City or Town, State	, Zip Code)
	and ealth m 27		Mr. Clarence Ster	n, Husban							MD 21550	
0	Pages 1 nent of H ant: If ite ary or otl		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Di cemetery, o	sposition (Nar crematory or c	ne or ther plac	(e)	Date	,	20c. Location - City	or Iown, State
Baltimore,	t Partimen tant:		' 4 □ Donation 5 □ Other (Specify)		Garrett						Oakland,	
Bal	permi Depar Impor any ir		21. Signature of Funeral Service License	1. do-b		Davi	d A	Burd	ock F	uneral	Home, P.	A.
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do not						d, MD 215.	Approximate
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8760,	ate be executed obly sician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as	a consequence of):							
.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as It.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ XNo 9 □ Unknown	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pi 5 □ Other (sp					23d. Date of o	lelivery Day Year
S, D	res that igned b	y PI	Part II. Other significant conditions con	tributing to death b	ut not resulting in th	e underlying o	ause giv	en in Part I.		23e. Did tob	acco use contribute	to the cause of death?
ğ	w require been sig should b		Diabetes mell	itus, H	ypertens	sion_				1 □ Ye	s 2.2XNo 3.∏	Probably 4 Unknown
Record	The law re ite has bee bage 2 sho	Completed	Hx of cerebro	vascula	r accide	ent				24a. Was as autops perform	y prior t ned? death	
/ita	i <b>cian</b> : Th certificate rector, pag	Bec	25. Was case referred to medical examiner?							check only on		
<u>5</u>	Physic this co	은	1 □ Yes 2X No		nt 2 ER/Outpa		Oth Oth	er: 4 🗆 Nur			nce 6 Other (S	pecify)
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DİX	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.	ury - At home, farm, c. (Specify)	street, factor	y, office		28f.	Location (St. City or Town		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical	29a. Certifier (Check only one)  1 ★ Certifying Phys 2 → Medical Examir	ner: On the best of the best of the basis of and manner sta	examination and/o	eath occurred r investigation	at the tin , in my o	ne, date and pinion, deatl	d place, and th occurred	at the time, da	ate and place, and d	ue to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	110		29		e number		25	9d. Date signed (Mo	
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		5	30. Name and address of person who co					ъ.	_			550
	TO THE STORY	Qini.	Doan1d R. Rich 31. Date filed (Month, Day, Year)	200	D. 1533 ar's Signature	Memoi	cial	Dri	ve 0	akland	d, MD 21	550
27	Sta Flegisti			007	ne As	Socialis	D					

			1 - For State Registrar	State of Maryla		ent of Health and ate of Death	Mental Hygien	tion of the S	25130
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	Exami		4a. Facility Name (If not institution, give			ity, Town, or Location of Dea	ith 4	c. County of Death	
			ATLANTIC G	eneral Ita	sp. tal	Berlin	į	NORCEST.	-/
	Funeral		5. Social Security Number 6. S		- Mont	der 1 Year   If Under 24 Hr	S. 8. Date of Birth	9. Birthplac	e (State or Foreign
	Director		227-36-7700	OM 20 9 2	Yrs.	ns Days Hours Mil	6 - 20 -		A
	p .		Usual Residence of Decedent  10a. State 10b. County	100.0	NA. Towns I was				
	aryla •ho	7		4 .	City, Town or Location			10d	Inside City Limits
	the Marylar 28e-f ehow	octo		ester /	DellIN				1 No
	death with the Maryla ems 23a or 28e-f ehor	Funeral Director	10e. Street and Number	. 11	10f.	Zip Code	10g. C	itizen of What Country	?
	ath w	rai	9715 Hea		DR	21811	Uc	rited S	tates
	er de	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was De	cedent of Hispanic Origin? ( specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Black, White, etc	
36	ours aft rai', or Exert	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give	1 □ Ye	2 No Specify:		Specify: 10.1	V
215-0036	72 hours after death with the Maryland natural', or Items 23s or 28e-1 show disal Exami, at must be notitled at	pe	15. Decedent's Ed	Year or Dates:	1 1Ca Danidada	. 10		101	<u>r</u>
5	c * 5	Completed	(Specify only highest gra	de completed)	16a. Decedent's U	isual Occupation <i>work done during</i> most of wo Tuse retired)	orking 16b.	Kind of Business/Indus	try
212	within and and and and and and and and and an	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)	7	nest, 2		touse wo	ole-
2	be filed withintal Hygiene.	ŭ	17. Father's Name (First, Middle, Last)				me (First, Middle, Maide		~~~
an	Mental Mental arked c	Be	TA 25 500	- h	e 0	E1:		,	
Maryland	d 2 should be filed th and Mental Hygi 7 Is marked other treumatic event, I	၉	19a. Informant's Name/Relationship (7	rborough:	10h Mailine Adda	(6)		mes	
Σ	12 s		Ele - D		190. Mailing Addr	ess (Street and Number or R	0 1.	1	1 1
ية	s 1 end f Healt item 2 other		20a. Method of Disposition		Place of Disposition (		Date 20c.	Location - City or Town	Charles
Baltimore,	0 0		Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crematory	or other place)	Date 200.	Location - City or Town	1
5	permit Pag Department Important: I any intury o		4 Donation 5 Other (Specify		UERGIEEN	cem. 7/	28/07 P	Jeliu m	1 21811
Ba	permit Depar Import any in		21. Signature of Funeral Service Licen	of as Tom	22. Name	and Address of Facility	Ult ARTEN F	UNERT 140	ne
	40200	0	cagor Kia	) 107-0	1221	7/ Wharton	RU ACC	UMAC VA	23301
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the dea	ath. Do not enter the n	node of dying, such as cardia	c or respiratory arrest,	In	proximate terval Between
ba	Physician		Immediate Cause (Final disease or condition	, Aspirat	100 Pa	Euroria.		4	nset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	15		14.	Car
	LAGITITIE		Sequentially list conditions.	0.	ge Den	rentres		17	Cours
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	1 . t. V			2
	kecute and Il-trans	am	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	voseuliv	Accidents			L'eous.
ő	be executed lician and burial-transit	<u>~</u>	resulting in death) cast	Due to (or as a conse	quence of):				
8760	e S e	Icai		d		196		-	
9	eath certificate attending phys i for use as the	Physician/Med	IF FEMALE:						
Box	ith ce tand	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		pregnancy		23d. Date of delivery	
	0 0 0	Sici	in the past 12 months? 1  Yes 2  No	4☐Pregnant at time of				Month Da	y Year
P.0	at the	Å.	9 🗆 Unknown						
	requires that the de een signed by the a rould be detached t	þ	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the c	ause of death?
Records,	w require been sig should b	ed					1 ☐ Yes 2	2 ☐ No 3 ☐ Probabl	4 Jallaknown
ပ္က	> 0 %	Completed					24a. Was an	24b. Were autopsy	findings available
ď	0 = 0	E					autopsy performed?	prior to comple death?	etion of cause of
ā	ician: Th certificate rector, pag	O	25. Was case referred to medical			26 Diago of Do	1 ☐ Yes 2 ☑ No	0 1 Yes 2	J No
Division of Vital	ysici is cer direc	ToB	examiner?	lospital: 1 ☐ Inpatient	ER/Outpatient 3□	Other	Home 5 Residence	6 DOther (Careta	
0	er th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe how inju		
<u>ō</u>	ath.	읉	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day fear)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
<u>Vis</u>	Atte octo by th	€	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	nome, farm, street, fact	ory, office	28f. Location (Street a	nd Number or Rural Ro	oute Number.
	al or	Certification;	- Inotticida	building, etc. (Speci	ny)		City or Town, Stat	·e)	
	To the Hospital or Attanding Physician: white 24 hours after death this certificator. After this certificator white the funeral director, completely filled in by the funeral director.	aic	29a. Certifier 12 Certifying Phy	sician: To the best of my kn	owledge, death occurr	ed at the time, date and place	a, and due to the causals	s) and manner as state	d.
	ne HC	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	ation and/or investigati	on, in my opinion, death occu	urred at the time, date an	d place, and due to the	cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			9c. License number	29d. Da	ate signed (Month, Day	, Year)
			1/1/261	1		DRADE	59 1	7/21/07	>
,		-	30. Name/and address of person who co	ompleted cause of death /Ite	m 23a) (Type Print)	2-070		1 100	
By	12		Nielolas Buredu	de und 1	707 /00	stal Healer	Franch	Tolo. 0 1	De l'AGUILL
	Sta	е	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	2	7 1 -manon	The series	01/179
	Registra		2 7 6	007	He longe	1. )			

DHMH 17 Rev 1/2001

700:09:55

DOB 6/20/14 DOD 7/21/07

Scarterough, Emira D. 229-36-490

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death

For State Registrar Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, Last)	ay Year	3. Time of Death						
an :al	Lloyd Albertus Semler				J	Month 2	4 2007	12:25 AM	
er	4a. Facility Name (If not institution, give street and number)	4b. (	City, Town, or I	_ocation of [	Death	4	c. County of Death	1	
	Washington County Hospital		gersto		Uro 0		Washingto		
	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. las</i> 1 1 1 2 1 5 1 7 1 9 1 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs. Mon			Min.	Date of Birth (Month, Day, Yea OV . 26,	1921 Mar	nplace (State or Foreign untry) 'y land	
	213-18-8360					100. 20,	1921 1101	yrand	
		Town or Location						10d. Inside City Limits	
ţ	Maryland Washington Hage	rstown						1 □ Yes 2 No	
irec	10e. Street and Number		. Zip Code			10g. (	Citizen of What Cou	untry?	
<u></u>	17423 Lexington	2	21740			US	Α		
ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		ecedent of His specify Cubar	panic Origin	1? (Specification Rice		14. Race - Amer Black, White		
굔	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1942	<b>-</b>		Specify:	00101110	an, 0.0.,	Specify: Whi		
Be Completed by Funeral Director	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 1940	)				-1			
ete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's (Give kind o	Usual Occupa If work done du DT use retired)	tion <i>uring m</i> ost o	f working	16b.	Kind of Business/I	ndustry	
E C	Elementary/Secondary (0-12) College (1-4or 5+)	Maintena				Po	wer Compa	anv	
ပ္သ	17. Father's Name (First, Middle, Last)	na i ii i e ii c	-	18. Mother's	Name (F	irst, Middle, Maid	•	3117	
ag .	Harry H. Semler Sr.			lda N	lae .	Shrader	,		
_C	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Add					or Town, State, Z	ip Code)	
		10834Å L	incoln	Ave.	Hage	rstown,	Maryland	21740	
		ce of Disposition netery, crematory			Date		Location - City or		
	1 X Burial 2 Ucremation 3 Unemoval from State	View Cer		1	Lv :	27 2007	Sharnshu	rg, Maryland	
	21. Signature of Fungral Service Lipens	22. Nam	e and Address	of Facility			•		
	Dutte Kh	Osbo	et Wil	neral Liamsr	Home	Marylan	5 South (	Conococheague	
	23a. Part. Enter the disease, or complications that caused the death.							Approximate Interval Between	
	Immediate Cause (Final disease or condition	Sold L	25/1110	,				Onset and Death	
	resulting in death)  Due to (or as a conseque	nce of):	OTTOTE	-				CIGIS	
	Sequentially list conditions, b. Chronic obstructive pulmoney dispose.								
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury								
am	that initiated events c.								
û	resulting in death) Last	nce or):							
cian/Medical Examiner	d								
/Me	IF FEMALE: 23c. If yes, outcome pf pregnand	ev					Ood Date of dali		
ian	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal d □ Pregnant at time of dea	eath 3 ☐Ector	oic pregnancy				23d. Date of deli Month	Day Year	
Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ui 5_10tile	(Speeny)						
, Ph	Part II. Other significant conditions contributing to death but not resulti	ng in the underlyi	ing cause give	n in Part I.		23e. Did tobacc	o use contribute to	the cause of death?	
Completed by	A cote recel forlyse					1 ☐ Yes	2 No 3√2 Pro	obably 4 Dunknown	
lete	asalasis					24a. Was an	24b. Were au	topsy findings available	
Ę.	0-1 1 0 1 1 -4					autopsy pertormed	prior to o	completion of cause of	
ပ္တို	25. Was case referred to medical			26 Place of	f Death //	1□ Yes 2□	No 1 ☐ Yes	2 □ No	
To Be	examiner?	R/Outpatient 3F	DOA Othe	r·			6 □Other (Spec	rifu)	
J	27. Manner of Death 28a. Date of Injury 2	8b. Time of Injury	28c. Injury Work			d. Describe how in		,	
1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
iţic	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of injury - At hom building, etc. (Specify)	e, farm, street, fa	ctory, office		28f	Location (Street City or Town, St	and Number or Ru	ral Route Number,	
Cert									
cal	29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination								
Medical Certification:	one) and manner stated.								
2	29b. Signature and title of certifier	200	29c. License		1/2		Date signed (Month		
		12	10	0 36 4	1 >	0	/174/20c	7	
	30. Name and address of person who completed cause of death (Item 2)		+ 4.	(25 pr	-5+	own	Daryla	nd 21740	
	31. Date filed (Month, Day, Year)  32. Registrar's Signatu		/ / / 1	- )					
ite ar	JUL 2 6 2007		ed -						
	William Carlot Makes	1. Santa	47 19						

St Regist

OH-12+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23,25,27,28a-f per me 870,08/16/07dhb

Reg. No. Pt I,II 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 A M Patricia Ann SNYDER **200 (** /Medical 4a. Facility Name (If.not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 📉 F Director 69 214-42-0998 July 23 1938 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Exaπiner must be notified at 1XYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 Funeral USA 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 2 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ene. than Elementary/Secondary (0-12) College (1-4or 5+) the 0 Cook Nursing Home Pages 1 and 2 should be filed and the filed and Mental Hygirint; If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Louis Henneberger Edna Marie unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) sortant; If Item 27 injury or other to Ann Herold - Daughter Box 4265 Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 7/27/07 Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andlomimona Physician /Medical Due to (or as a consequence of) Examiner orman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and Due to (or as a consequence of): attending physician Box 68760 CENTER Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö sbeen signed by the should be detached ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Of Unknown Etiology Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No due to 24a. Was an this certificate has autopsy performed? Yes 2 No Probable Aspiration of Food bolus 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation Subject likely choked on food 1 ☐ Yes 2 XNo 07/11/2007 Unknowh <sup>M</sup> after death 2 Accident (Street and Number or Rural Route Number) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 750 Dual Highway, Hagerstown, Nursing Home within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 5H-5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Earl Eugene Strailman 4:05P July  $\tilde{21}$ 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Citizens Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Dec 12 Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 76 218-26-7914 1927 Charles Town WV Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 120 Ninth Avenue 21716 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Tvt Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 12 should be filed within 72 incurt hand Mental Hygiene.
27 is marked other than "natural" 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Lighthouse of the Blind Elementary/Secondary (0-12) College (1-4or 5+) Laundry Man Baltimore, MD 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl V. Strailman Elvie B. Nicewarner 1 and 2 should traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a Doris M. Crone, Sister 6269 Ed Crone Lane, Frederick, MD Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 ☐Removal from State Edge Hill Cemetery 7/25/07 Charles Town, WV 4 □ Donation 5 1 Other (Specify) 21. Sign and of Furbial Larrice To nse 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, Barbara A. Williams, Owner 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. physician use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by No. 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 □ EB/Outpatient 3 □ DOA this nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death
1 Natural
2 ☐ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Iniury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the I 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of ce

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

within 24 hours a 1

CAC

State Registrar

120 31. Date filed (Month,

Signature and title of ce

of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Blook Chestertain MD21620

			101	epartment of Health and N Certificate of Death		ene g. No. 25   4	
	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	
	/Medio		Jean Mary Bruce Spangler  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 16, 2007  4b. City, Town, or Location of Death  4c. County of Death		
			Carroll Hospital Center	Westminster		Carroll	
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, July 5,	Year) 9. Birthplace (State or Foreign Country) England	
	/land		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits	
	e Man	ctor	Maryland Carroll K	eymar		1 ☐ Yes 2 <b>X</b> No	
	vith th	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?	
	s 23s	eral	5800 Middleburg Rd.  11. Marital Status 12. Was Decedent Ever in U.S.	21757	acifu Vac as Na	USA  14. Race - American Indian,	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural," or items 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notilised at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ♥ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ♥ No If Yes, Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes ¾☐ No Specify:</li> </ul>	Rican, etc.)	Black, White, etc.  Specify: White	
5	72 ho	Completed	15. Decedenl's Education 16a. ( (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work	ina	6b. Kind of Business/Industry	
121	within	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		State of Maryland	
	filed v Hygie other t	Co	12 EXE	cutive Secretary	e (First, Middle, M	(Social Services)	
Maryland	Mental Merked o	To Be	Ronald Robert Bruce Bannerman	Mary Ne:			
ary	2 should and Men ie marke sumatic			Mailing Address (Street and Number or Run		City or Town, State, Zip Code)	
Σ,	1 and 2 Health em 27 ither tre				Westmins		
Ö	it of H if of H or oth		I Laboural 2 Cremation 3 Linemoval nom State	crematory or other place)		Oc. Location - City or Town, State	
aftimore,	pernit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		4 □ Donation 5 □ Other (Specify) MeadOW  21. Signalure of Funeral Service it icensee	Branch Cem. 7/21		estminster, Maryland	
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	Thysisian		shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory affe	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)  a.   Due to (or as a consequence of			Days	
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/ita	ysician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?	26. Place of Deal	h (Check only one	)	
ō	E 5 2	<sup>2</sup>		atient 3 DOA Other: 4 Nursing Ho	me 5 Resider	nce 6 Other (Specify)	
0	ding I th. : After s funer	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year) Injury  28b. Tir		20d. Describe no	willing occurred	
Divis	in Dirt	Certification:	3 Surcide 6 Could not be determined 28e. Place of Injury - Al home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)	
	To the Hospitai within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Clask only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cared at the time, da	use(s) and manner as stated. le and place, and due to the cause(s)	
	To the To the comple	Ž	29b. Signature and title of certifier	29c. License number	1	d. Date signed (Month, Day, Year)	
ΑŪ	28		Willy mo	D005813	フ	7/17/07	
, ,,,,	5		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	£ £	MP 21157	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Segistrar's Signature  JUL 19 2007	Sparke	en nst e	70.5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Physician July  $a^{M}$ 2007 20 8:08 Doris Marie Smelser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 5 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X MD 1922 Director 219-05-7970 84 Usual Residence of Decedent 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1127 Yes 2 □ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I 21157 USA 39 Chase Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Mae Taylor James Edward Shilling 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Samuel E. Smelser/Husband</u> 39 Chase Street Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/2472007 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Zart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ratum onin ASPIRA RUN **Physician** week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading L. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed burial-transi Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 MASI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has page 2 s autopsy certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specity) 1 ☐ Yes 2 No DONG HO OZE 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 17 Rev 1/2001

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THOMAS GALVW

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LI MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar FH, TCHD, 07/27/07, sbb Certificate of Death Amended, 19a. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8:50PM M TIMOTHY EDWARD SHORTALL 15 2007 JULY/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29600 TARBUTTON MILL ROAD TRAPPE TALBOT If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
NC **Funeral** 42 NOV 6, 1964 Director 219-94-3211 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No TRAPPE MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21673 29600 TARBUTTON MILL ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐**X**lo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry SHORTALL (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SELF-EMPLOYED FARMER AGRICULTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY LEWIS THOMAS EDWARD SHORTALL LIMOTHY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY A: LEWIS SHORTALLT Mother PO BOX 94, TRAPPE, MARYLAND 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WHITEMARSH CEMETERY 7/19/2007 TRAPPE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 MERCERON K OHA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Owne Chraum Physician Exers Smonths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2∭ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Nursing Home} \) 5 \( \text{Nursing Residence} \) 6 \( \text{Other} \( \text{Other} \) (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 0 6

Registrar
DHMH 17 Rev 1/2001

State

DAVID SMITH, M.D. 8221 TEAL DR., SUITE 302, EASTON, MD 21601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 8 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Day **Physician** ein 1,2007 01 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ta Konga 5. Social Security Number 401019L George If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace **Funeral** (State or Foreign Months Days 1 □ M 2 🗓 F Director 216-32-1363 2/26/1934 Baltimore, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD North Bethesda ¶∑Yes 2 No Montgomery Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5802 Nicolson Lane #201 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 73. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Nitzberg Anna Blumberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherwin Stein - Husband 5802 Nicolson Lane #201 North Bethesda MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
United Hebrew Cemetery Date 20a, Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/25/07 Baltimore, MD 22. Name and Address of Facility
Danzansky-Goldberg, Memorial Chapels Inc
1170 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Lices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Q PS 5 /Medical Due to (of as a consequence of): Examiner hoon. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or and a consequence of) burial-tran Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 2 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ျှ 1 Expatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural
Accident Injury 5 Pending 1 ∏Yes 2 ∏No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation in my various day. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifing 29c. License number 29d. Date signed (Month, Day, Year) 053850 30. Name and Steeler (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) edistrar's Signature State 2007

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Physicia		Registrer  1. Decedent's Name (First, Middle, Late		C			2. Date of Dear Month	Day	Year	e of Death
/Medic	al .		LLIAM	SCHEFF			07		2007 15:	15 M
Examin	er	4a. Facility Neme (If not institution, give		anital		or Location of Dea Dakland	th	4c. County of	Garrett	
		Garrett County Number 6. Social Security Number 6. S		(In yrs. last birthda)	) If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth		9. Birthplace (Sta Country)	ate or Foreign
uneral rector		579-38-0909	XM 2□F 7	7 Yrs.	Months Days	Hours Mir	Feb. 2	2, 1930	Washing	ton, DC
*	F	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	Location				10d. Insid	ie City Limits
ode p	0	MD Gari	rett	•	0ak	land			1 🗓	Yes 2 □ No
r 28a	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of W	/hat Country?	
importent: if item 27 ie marked other then "natural", or items 33a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be multied at 2008.	O B	329 N. Fourth St.	•			21550			USA	
E E	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		<ol> <li>Was Decedent of If Yes, specify Cu</li> </ol>	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race Black	e - American India k, White, etc.	n,
Xerrile	by F	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	·	1 ☐ Yes 2 🗓 No	Specify:		Specify:	Whit	te
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		12 17. Father's Name (First, Middle, Last	•)	5	uperviso		ame (First, Middle,			
0 0	o Be	Walter W.	Scheffel,	I		Sarah	Eliza	abeth	Ambei	n
itemi	၉	19a. Informant's Name/Relationship (	(Type, Print)	19b. Ma	iling Address (Stree	et and Number or I	Rural Route Numbe	r, City or Town,	State, Zip Code)	
er tre		George A. Scheffe	el, Sr./ Br			Orive, Oa			21550	
or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	cemetery, ci	position (Name of rematory or other p		Date		City or Town, Sta	
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ransıı	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· CORONAR	y rech	OMIA An	o Post O	Rongris 1	LMPARH	1165	
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use as	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		3 □Ectopic pregnar 5 □ Other (specify)			Мо	nth Day	Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- Registrar State of Maryland / Department of Health and Mental Hygiene
Registrar Registrar Registrar Registrar Registrar Reg. No. 3. Time of Death p 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ELWOOD STEEN 2007 CLEATUS JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

AUG • 25, 1932 Peninsula Regional Medica Conten Wicomico t hirthday ae (In yrs 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F DELAWARE 214-32-0354 74 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at DELAWARE SUSSEX GREENWOOD 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10197 WOODYARD ROAD 19950 AMERICA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐**X**No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry POULTRY Elementary/Secondary (0-12) College (1-4or 5+) POULTRYMAN 7YRS. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY THOMAS STEEN DELLA MAE ANDERSON ပ 19 Mon Advisor Ann Dombri O Aug Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LEONA B. STEEN WIFE GREENWOOD, DELAWARE 19950 20b. Place of Disposition (Name of ODD FELLOWS CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremeation 3 ☐Removal from State JULY 24,2007 SEAFORD, DELAWARE 4 Donation Other (Specify) 21. Signature of June I Service Licen MATSON YATES" FUNERAL HOME, INC. SEAFORD, DELAWARE 19973 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or complications that can st only one cause on ea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** 2 day PS: 5 /Medical Due to (or as a consequence of): **Examiner** lo replanting Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Oh structure attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 I Inknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Lirector: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760,

0

the the

> State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature at title of certifier 29c. License number

Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

100 Karl Gerall 94 Silvebyen MB 21801

egistrar's Signature

			1 - State of Maryland / State of Maryland / 23a, Pt1, II, 25, 2	Departme 28b e Certifica	nt of H	lealth ar MF C8 Death	nd Mental Hy 7 <b>0,08/02/0</b>	giene <b>7dhb</b> Reg. No. 2	007	2511
	Dhyoisi	ø.	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medi		Simon Thomas Stouffer				July		007	2.35 PM
7	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. Cit	y, Town, or	r Location of	Death	4c. County	of Death	
		€.	Washington County Hospital		erst				ingto	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b.	Yrs. Months		If Under 24 Hours	Min. (Month, Da	ay, Year)	9. Birthp Coun	lace (State or Foreign htry)
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	3a ol	0	13301 F Hunter Hill Apt.	21	742			U.S.A.		
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of H	ispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Rac	e - Americ	
Q	after or Ite mine		1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give	1 ☐ Yes	2 ☑ No	Specify:	Puerto Ricari, etc.)		ck, White,	etc.
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X Q Q	the death certific y the attending p iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deat	th 3□Ectopic	pregnancy	CERIII			te of delive	ery Day Year
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0	S S	ို	X -	outpatient 3 [		4 □ Nurs	ing Home 5 Res			y)
	ing F After uner	in o	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b.  (Month, Day Year)	Time of <b>am</b> known <sub>M</sub>	28c. Injur Work		28d. Describe	how injury occur	red	
<u>s</u>	ttenc leath stor: the	cat	3 Suicide 6 Could not be 28e Place of injury. At home		1 U	165	TAU A	Street and Numb	or or Dur	al Pouto Number
DIVISION	or A after of Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	one	ny, omoe		City or To	wn, State)		Make Number,
	pital ours a eral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge		ed at the tin	me. date and				tated
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation	on, in my o	ppinion, death	occurred at the time	, date and place,	and due to	o the cause(s)
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral.	Me	29b. Signature and title of certifier	1100 2	9c. License	e number	164	29d. Date signe	d (Month,	Day, Year)
1	- > <del>-</del> 0		MUNT		DI	106	22	1414	Ar.	2007
•			30. Name and address of person who can pleted cause of death (Item 23a)	(Type, Print)				1000	50,0	
	6	W.	BRAGO UM CANN-MD PABLA	WKAM	u/ (1/k	U/ DA	ARBA	2887UM/	MD	2177/1
脂	Sta	ate	31. Date filed (Nonth, Day, Year) 2007 32. Registrar's Signature	A	4010	- W	110 000	4 40 - 4 49	4-1-60	
	Regist	rar	AUG U Z ZUUT Janes St. J.	GOODEN.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ritter Tuttle Year **Physician** July 19,2007 2:00  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery National Lutheran Home Rockville
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign
Country) Months Days Hours Min 1 □ M 2√2 F 223-58-4932 100 Yrs. Director Jan.24,1907 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Spite. 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at Montgomery Rockville Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9701- Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 Is marked other then "natural", or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ā Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George W. Ritter Rosa Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Tuttle, Jr - Son 9707 Ceralene Dr. Fairfax, Va. 22032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny injury or once. Oak Grove Cemetery 7/25/2007 4 ☐ Donation 5 ☐ Other (Specify) Portsmouth, Va. 21. Signature of Funeral Service Licentsee 22. Name and Address of Facility 2222-Wisconsin Ave., NW Will Hysong Co., Inc. 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Washington.DC Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician dayo heumen, a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No the detached Physi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 🗗 🐪 O 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2000 the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending after death. Director: Af investigation M 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à To the Hospital or At within 24 hours after of To the Funeral Direct 4 Homicide filled 12 Certifying Physician: To the bast of my knowledge death conumed at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29c. License number

SAMUZL 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

MALLERMA 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

malles mo

DHMH 17 Rev 1/2001

D0050612

29d. Date signed (Month, Day, Year)

970 1- VEIRS BR. ROCKVILLE MO 20850

July 20, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

For	State of Maryland / Department of Health and
State Registrar	Certificate of Death

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		•	1 - State Registrar			Certifi	cate of i	Death		Reg. No	).	
			1. Decedent's Name (First, Middle, La.	st)	•••				2. Date of D	eath Da	y Year	3. Time of Death
	Physici /Medio		Patricia A. Ta	ylor					July	16	2007	10:15P M
St. Ja	Examin		4a. Facility Name (If not institution, give	e street and number)		4b.	City, Town, o	Location of Death	1	40	. County of Death	
			Annapolis Nurs	ing & Reh	ab		Annap				Anne Ar	
	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2X0 F	(In yrs. last bi	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of B	ay, Year,	9. Birth	place (State or Foreign ntry)
	Director		231-40-1798 13	7.	70	113.			Sept	6 1	936 Ten	nessee
	and and		10a. State 10b. County		10c. City, Tow	n or Location	n					10d. Inside City Limits
	Mary	ğ	Maryland Anne A	rundel	Lot]	hian						1 ☐ Yes 2√2 No
	r 28a	Directo	10e. Street and Number			1	Of. Zip Code			10g. C	tizen of What Cou	ntry?
	h with		1085 Lower Pin	dell Rd.			2071	1			USA	
	deat	Funerai	11. Marital Status	12. Was Decedent E-	ver in U.S.	13. Was	Decedent of H	lispanic Origin? (San, Mexican, Puert	pecify Yes or N	0-	14. Race - Ameri Black, White	
21215-0036	iges 1 end 2 should be filed within 72 hours after death with the Maryland to f Heelih and Mentel Hygiene. If item 27 is marked other then "natural", or itame 23e or 28e-f ehow or other traumatic event, the Medical Exprimer roual be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Mount Married 4 ☐ Divorced	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	•		res <b>ڳ</b> ∑ No	Specify:			Specify: Wh	
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7	ygier tt,	ပိ	12th	0	E	vents	Cord	inator  18. Mother's Nan	- //**			ates Army
and	be fill d ott	Be	17. Father's Name (First, Middle, Last,								,	
3	J Mer narke	ဥ	Thomas E. Pace  19a. Informant's Name/Relationship (	Time Drint	101	Mailian A	ddana (Stront	Jossie				a Cada)
Maryland	d 2 st th and 7 is r traur		Clara Lancaste									
	1 end Heelt em 2		20a. Method of Disposition	r (Miece)	20b. Place o	f Disposition	Name of	Pindell	Date L		ocation - City or T	
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Baltimore,	글본란출 .		21. Signature of Funeral Service Licer	70000	TIC OI (			e of SacilSon				, riu.
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San .	Physician		Immediate Cause (Final disease or condition	BRETS	7 CAa	KER	West	1 ME	TASTA	55	S	V-Ears
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						ι
	ZAGIIIIIO	پ	Sequentially list conditions,	b	consequence	of):						
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	eath certificate be executed attending physicien and for use as the burial-transit	xar	that initiated events resulting in death) Last	CDue to (or as a	consequence	of):						
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.89	tificat g phy as th	Medical										
Вох	h cert endin		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	3 □Edd	opic pregnancy	,			23d. Date of deliv	
B	0 0	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at t			ier (specify)				Month	Day Year
P.O.	at the I by the stach	4	9 Unknown									4
Ś	8 70 8	þ	Part II. Other significant conditions of	contributing to death but	t not resulting	in the under	lying cause giv	en in Part I.			/	the cause of death?
ord	w require been sig should b	Completed							11-	Yes 2		bably 4 DOTKHOWN
ec	e law has b	nple							24a. Wa aut	opsy	prior to o	opsy findings available ompletion of cause of
=		ပိ							1 ☐ Yes	formed? 2 N	death?	2□ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
ot	S 5	ည	1 Yes 2 No  27. Manney of Death	I 🔲 Inpatien		utpatient 3	DOA Oth	4 Nursing H	lome 5 ☐ Res 28d. Describe		6 □Other (Spec	ify)
Division of Vital Records,	Jing I	0	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Injury	28c. Injur Wor	yat k? Yes 2 □No	260. Describe	now inj	ary occurred	
Sic	i or Attending efter death. Director: After in by the fune	Ica	2 Accident investigation 3 Suicide 6 Could not b		rv - At home, f				28f. Location	(Street a	nd Number or Ru	al Route Number.
<u>≤</u>	effer Dire	Certification:	4 Homicide determined	building, etc.		,	,,		City or To	own, Sta	re)	
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	nysician: To the best of niner: On the basis of	f my knowledg	e, death occ	curred at the tir	me, date and place	, and due to the	e cause(	s) and manner as	stated.
	To the H within 24 To the Fi complete	Medical	one)	and manner stat		TOP OF HIVES						
	With To	7	29b. Signature and title of certifier	Da 1.	, (	$\supset$	29c. Licens		,	29d. D	ate signed (Month	DO
	1 01	M	Janella	KUN	un	^	00	1970	_	17-	JULYD	
	(DOS		30 Name and address of person who	ORF, MD	ath (Item 23a)	(Type, Prin	1) =	110a.D.	this.	HS	ille N	18702 M
	100		31. Date filed (Month, Day, Year)	32. Pegistra	r's Signature	400	COOB	UNY XOI	117-1	, ,0	. , , \	
	Sta	ne i		3.000	- 3							

State Registrar

JUL 2 0 2007

32. Pegistrar's Signature

Stew & Specific

DHMH 17 Rev 1/2001

laceo Trader	State of Maryland / Depa	rtment of Health and Mental H	2 111	7 2515
Amended B	For State #5. FH TCHD, pa 07/20/07 Cer Decedent's Name (First, Middle,Last)	unicate of Death	Reg. No.	3. Time of Death
Medical Examiner	Maceo Roger	Trader	Month Day Year July 13, 2007	0707 hrs
4	a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	4b. City, Town, or Location of Death Salisbury	Wicomico	
Director	Social Security Number 6. Sex 7. Age (In yrs. le	ast birthday)  If Under 1 Year If Under 24Hrs  Months Days Hours Mire  Yrs.	Foreig	thplace (State or in untry) MD
2	sual Residence of Decedent  Da. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
š "	Md. Dorchester C	ambridge	10g. Citizen of What Cour	1 Yes 2 No
the Maryland a or 28a-f sh tified at once	0e. Street and Number	10f. Zip Code		nu y ?
	613 Bradley Ave.  1. Marital Status 12. Was Decedent Ever in U.	21613 S. 13. Was Decedent of Hispanic Origin? (S		ican Indian, Black,
or items 23 must be no	Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	, , ,	
ural", miner	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/	C.K
5-0036 ed within 72 hours af other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	tired)	
0036 within iene. er tha Medic	11	Brick Layer	Construc e (First, Middle, Maiden Surname)	t ion
and 2 should be filed within 7 and 2 should be filed within 7 leath and Mental Hygene. tem 27 is marked other than traumatic event, the Medical To Be Comple	7. Father's Name (First, Middle, Last)  Roger Trader	Tulla	Allen	
ore, MD 2121 ss I and 2 should, be fi ss I fact 21 is marked her traumatic event, To Be	9a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State	
P, MD and 2 sho fealth and item 27 is traumati	Karen Trader / wife  Oa. Method of Disposition 2Cb.	715 W 5th St C	hester Pa. 1901. Date 20c. Location - City of	Town, State
	Burial 2 Sremation 3 Removal from State	crematory or other place)	/23/2007 Dover, DE	
Baltimo permit. Page Department of Important: injury or ott	4 Donation 5 Other Specify: Ca	22. Name and Address of Facility Re	nnie Smith Fune	ral Home
	34. Fart I. Enter the disease, or complications that caused the death	524 Race St.,	Cambridge, Md. 2	1613 Approximate Interval
Physician /Medical	failure. List only one cause on each line.		or respiratory arrest, shoot, or mean	Between Onset and Death
Examiner	mmediate Cause (Final disease or condition resulting in death)  a Congestive Heart Failure to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the conse			
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ted dansit <b>Exa</b>	events resulting in death) Last  Due to (or as a consequence of d.	or): 		
10, te be executed ysician and burial - transit	UNPENDED AMENDED			
760, ficate be g physics the burn/Med	F FEMALE:  3b. Was decedent pregnant in the  23c. If yes, outcome of pred  1 Live birth	Ectopic pred	23d. Date of delive	ry Day Year
Box 6876 e death certificate the attending phy ed for use as the thysician/M	past 12 months?	2		
box 6876 the death certificat by the attending phy ched for use as the	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death?
P.O es that igned be detay	Chronic Alcoholism; Hypertension		1 200 300 - 1 2 2 2 2 2 2 2 2	obably 4 V Unknown
rds, requir			autopsy prior to	autopsy findings available in completion of cause of
Records, P.C. The law requires tha ficate has been signed , page 2 should be det. Completed by			performed? death?  1 ✓ Yes 2 No 1 ✓ Yes	res 2 No
tal F	25. Was case referred to medical examiner?  Hospital: 1  Inpatient 2	26.Place of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Check Property of Death (Ch	k only one) sing Home 5 Residence 6 Oth	er:
of Vi 3 Physi ter this eral dii	27 Manner of Death 28a, Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion (tending eath.	1 Natural 5 Pending Accident Investigation (Month, Day, Year)	1 Yes 2 No		
Division of Vital Records, P.O. Box 6876 spiral or Attending Physician: The law requires that the death certificat nearal Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the Certification: To Be Completed by Physician/M	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	Rural Route Number, City
	4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowle	dge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as st	ated.
To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurre	d at the time, date and place, and due to	the cause(s)
F × F × B	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (N July 14, 2007	noπth, Day, Year)
	30. Name and address of person who completed cause of death (Ite			
7	Laron Locke MD. Assistant Medical Examiner		1201	
State	31. Date filed (Month, Day, Year) 2007 32. Redistrar's Signa	ture death		
Registrar DHMH 17 Rev 1/2001	- July	ORIGINAL		

		·	For State of M.	ਕੀਪੁੱਕਿਸਰੀ ਐਦੇਸ਼ੈਬਿੰਜਜ਼ਿੰਜ਼ੇ of ਸਵਿਕਰਿ ਕਿਸਟੀ Certificate of Death	Méntai Hygie <sub>Reg.</sub>	2007 20101
3	Physici /Medic		Decedent's Name (First, Middle, Last)     Everett Hughes	Upton	2. Date of Death Month July 22	Day 2007 Year 2031 M
	Examin		4a. Facility Name (If not institution, give street and number) Broadmore Assisted Living	at Hagerstown Hagerstown		4c. County of Death Washington
, de la	Funeral Director		578-05-4407 1 <sup>1</sup> X <sup>M 2□ F</sup>	92 Yrs. I last birthday) If Under 1 Year I If Under 24 Hrs Months Days Hours Min.	B. Date of Birth (Month, Day Ye July 15,	9. Birthplace (State or Foreign Country) Louisiana
ines	show	J.	Usual Residence of Decedent 10a. State 10b. County  Maryland Washington	10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	with the M a or 28a-f	Directo	10e. Street and Number 1175 Professional Court	10f. Zip Code 2174		Citizen of What Country?
36	s after death or Items 23	by Funeral Director	11. Marital Status  12. Was Decedent Armed Forces?  12. Wes Decedent Armed Forces?  12. Wes 2 □	Ever in U.S. 13. Was Decedent of Hispanic Origin? (St. 17 Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show amy injury or other treumatic event, the Medical Examinant in multiplial at angle.	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4ors)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking	o. Kind of Business/Industry Public School System
nd 21	be filed wi tal Hygien d other th	Be	17. Father's Name (First, Middle, Last)	Teacher 18. Mother's Na	me (First, Middle, Mai	den Sumame)
Maryland	and Men Is marke	J.	Edwin Everett Upton  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R		
nore, N	ages 1 and of Health it fitsm 27		David Everett Upton/Nephew  20a. Method of Disposition  Description  D	7609 Chelton Road, Bet  20b. Place of Disposition (Name of cemetery, crematory or other place)  Mt. Olivet Cemetery July 2	Date 200	Location - City or Town, State
Baltimore,	permit. P. Departme Importent any injury once.		21. Singly of Funeral Genore Licensee	M00021 22. Name and Address of Facility Keeney and Basfo	ord Funeral	L Home
36	Physician		shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition		c or respiratory arrest,	rederick, MD 21701 Approximate Interval Between Onset and Death
	/Medical Examiner	er	Due to (or as Glucom	a consequence of):		
60, F/	icate be executed physicien and s the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):		
k 68760,		Medical	IF FEMALE:			
P.O. Box	the death certifi y the attending I iched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
	The law requires that the derate has been signed by the a cage 2 should be detached f	by	Part II. Dther significant conditions contributing to death t	out not resulting in the underlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Minknown
II Reco		Completed			24a. Was an autopsy performed	
Division of Vital Records,	To the Hospital or Attending Physicien: Th within 24 hours affect death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1	ent 2 ER/Outpatient 3 DOA Other: 4 Nursing	ath (Check only one) Home 5 Residence 28d. Describe how	e 6 Other (Specify) ASSISTEM
Divis	tal or Attar	Certification:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, street, factory, office tc. (Specify)	28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, State)
	he Hospi n 24 hou he Funer pletely fill	edical		t of my knowledge, death occurred at the time, date and plac of examination and/or investigation, in my opinion, death occ tated.		
)	To t To t	Σ	29b. Signature and title of certifier  Tank	29c. License number		Date signed (Month, Day, Year)
	ь		30. Name and address of person who completed cause of	814ED 10-100	of al	MO 21740
	Sta Registi		31. Date filed (Month, Day, Year) 34. Regist AUG 0 6 2007	rar's Signature		

DHMH 17 Rev 1/2001

			1 - For State Ragistrar	State of Man	•	artment of F		d Mental H	ygiene Reg. No.	2007	2515	) [
	Physicia	20	1. Decedent's Name (First, Middle, Las.			· ·		2. Date of D Month	Death Day	Year	3. Time of Death	h
	/Medic			elyn Kneuke	r Webb			Ju1y	29	2007		M (
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o		Death		County of Dear	th	
			Deer Ridge Manor  5. Social Security Number 6. Se	7 Ace //	n yrs. last birthday	Risin	g Sun	Hrs. 8. Date of 8	lirth	Cecil	thplace (State or Fore	eian
	Funeral Director			<sup>2</sup> M 2 <b>X</b> 0F 81	Yrs.	Months Days		July 7	, 192	.6 Nev	v Jersey	ngir
-	<b>3</b> 35		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or L	ocation					10d. Inside City Lim	nits
fonds	o ba	ō			E1kton						1 <b>X</b> Yes 2 □	
d.	28a-	Directo	Maryland Cecil  10e. Street and Number		EIKLUII	10f. Zip Code			10g. Citi	zen of What Co	j ountry?	
dim	3a or	ā	103 Windsor Driv	· e		21921			Ţ	Jnited S	States	
Acok.	E a 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or N		14. Race - Ame	erican Indian,	
chould be filed within 70 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or itema 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:	rueno racan, etc.)		Black, White	hite	
3 6	natu	etec	15. Decedent's Ed (Specify only highest grad		l (Give	edent's Usual Occup e kind of work done	durina most of	f working		nd of Business	,	
di.	e P e	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	d)			nited S		
1 20	lygie nt, th		12 17. Father's Name (First, Middle, Last)		CI	erk	18 Mother's	Name (First, Midd		ostal S	ervice	
,	ontal cove	9 Be	Andrew Kneuker					ia Jordan		<i></i>		
	M M M	၉	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Mail	ing Address (Street				r Town, State.	Zip Code)	-
0.5	Ith ar 27 is r treu		Andree Whitlock/			E. Park P						
5	f Hea itam othe		20a. Method of Disposition		and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	osition (Name of ematory or other place		Date	-	cation - City or		
Page 1 and 9	ry or		1 🗓 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval hom State		's Cemete	IAU	igust 2, 007	Per	rvville	, Marylan	d
	Departm Imports eny inju		21. Signature of Funeral Service Licens		2	2. Name and Addre	ss of Facility				,,	
3 8	22 2 3		Daniel J	8. theks	1 ا	icks Home 03 W. Sto	ckton	Street, E	lkton	. Mary	and 21921	
	hysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Lymph	oma	iter the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death	
	xaminer			Due to (or as a c	onsequence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a e	onsequence of):							
he executed	sicien and burial-transit	Examiner	that initiated events	c.								
2 0	urial-		resulting in death) Last	Due to (or as a c	onsequence of):							
ote	physicien the buria	dlca		d								
) iji	ding p	/Me	IF FEMALE:	23c. If yes, outcome of	oregnancy.		-			2010	C	
The law requires that the death certificate	the attending p	Physician/Medical	in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	<i>'</i>		.   '	23d. Date of de Month	Day Year	
10,	ed by the detached	Phy	9 🗍 Unknown		-4 Min - in Alan		- '- BI	22a Die	d tabaaaa	an anatributa t	the cause of death?	_
, iras	signed ld be det	d by	Part II. Other significant conditions co	ontributing to death but h	ot resulting in the i	underlying cause giv	en in Parti.		] Yes 2 [		robably 4 Onkno	
3	s been s	Completed						24a. W		24b. Were a	utopsy findings availa	able
9 4	ate hes	m o						pe	topsy formed?	death?	completion of cause	af
ç	certificet irector, pa	0	25. Was case referred to medical				26. Place of	1 ☐ Yes		1016	2 140	
Ciavi	direc	To B	examiner? 1 🗆 Yes 2 🗹 No	Hospital: 1 Inpatient	2 ER/Outpatie	int 3 DOA Oth		ng Home 5 ☐ Re		6 X Other (Spe	city) Living	
5	h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time (	of 28c. Injur	y at k?	28d. Describ	e how injur	y occurred		
1	leath. tor: After this certificete he the funeral director, page	atle	2 Accident investigation				Yes 2 □No					
4	after deatl Diractor: In by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, si Specify)</li> </ul>	treet, factory, office		28f. Location City or 7	(Street an Own, State	d Number or R )	ural Route Number,	
the Hoenital or Attending Physician:	within 24 hours after death. To the Funeral Director: completely filled in by the f.	ledical Ce	(Check only 2 Medical Exam	/sician: To the best of ninar: On the basis of ex	amination and/or in	th occurred at the til	me, date and p	place, and due to the	ne cause(s) e, date and	and manner a	s stated.	
e 4	thin 2 the mplet	Med	one)	and manner stated	1.	29c. Licens				e signed (Mon		
Ę	. <b>5</b> 0 0 €		29b. Signature and title of certifier	ides 5 M.	λ	_		2				
					<i>U</i>		2332		/	. 3/. <i>2</i>	007.	
	3		30. Name and address of person who o	completed cause of deat	n (item 23a) (Type	Frinti)	-00	FOLT	mi	1262	1	
			J.J Jackdo.	s MD. I	1 0 / \ <i>I</i> OT/	h of our	L (30)	EVELA	n'IL	ノイフユ	1.	

DHMH 17 Rev 1/2001

Evelyn Webb

ORIGINAL

			For State Registrar	State of Ma		d / Depa		of H	ealth a		lental Hy	giene	0.0	7	25153
			Registrar  1. Decedent's Name (First, Middle, L	a et l		Cer	lilicate	OIL	Jealii		2. Date of De	Reg. No.			3. Time of Death
	Physicia	an	Edith Chloe Wel	,							Month July	Day 28	20	ear	
	/Medic	al	4a. Facility Name (If not institution, gr				4h City	Fower or	Location o	f Death	July		County of		3:10 P M
	Examin	er					Fred			n Dealii			eder		
			Northampton Manor  5. Social Security Number 6.			ast birthday)			If Under 2	24 Hrs.	8. Date of Bir	th			lace (State or Foreign
	Funeral Director			1□M 2∏F	82	Yrs.	Months	Days	Hours	Min.	Oct. 1	av. Year)		Cour	h Carolina
			Usual Residence of Decedent												
	how		10a. State 10b. County	1-		Town or Lo								1	Od. Inside City Limits
	B Ma	cto	Maryland Freder	LCK	Emm.	itsbur	8 								1 ☐ Yes 2 ऄ No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citiz			•
	ath w	ra I	9135 Waynesboro					1727					ed S		
	tams	nne	11. Marital Status	12. Was Decedent I Armed Forces?		5.   13. \	Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)- 1	4. Race - Black,		an Indian, etc.
36	s afte	Ϋ́	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No		1□Yes 2	₹ No	Specify:				Specify:	whi	te
8	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Itams 23a or 28a-f show dother than "natural", or Itams 23a or 28a-f show avent, I'm Medical Esaivi act must be multified at	Completed by Funeral	15. Decedent's I			16a. Deced	dent's Usua	l Occupa	ation			16b. Kin	d of Busin	ness/inc	dustry
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72	filed with Hygiene. othar thar	E O	Elementary/Secondary (0-12)	College (1-4or 5	)+)	Propr	cieter					Re	staur	ant	
b	Hyg Hyg otha	Be C	17. Father's Name (First, Middle, Las	it)					18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)		
<u>a</u>	lic av	To B	Walter Story						0da	Tow	nsend				
Maryland 21215-0036	2 should and Men is marka raumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or or Rura	al Route Numb	er, City or	Town, Sta	ate, Zip	Code)
Σ	D = - =		Linda Winfield /	daughter						1 Rd	., Smit	hsbu	rg, N	1D	21793
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	Bemoval from State	20b. Pl	ace of Dispo emetery, cren	sition (Nam natory or ot	ne of ther plac	e)	[	Date	20c. Loc	ation - Ci	ty or To	wn, State
Ĕ	Pag ment ant: I		'4 □ Donation 5 □ Other (Spec		0ak	Lawn 1	Memor:	ial	Garde	n Au	g.1, 2				
alt	permit. Departi Importi any inj		21. Signatur of Fun ral Service Lig	<b>V</b> SD0			2. Name an			,		504			
<u> </u>	90 E # 9		Jast Jen	ette			icket					Myer	SVIL	Le,	
			23a. Part1. Enter the disease, or con shock, or heart failure. List on	nplications that caused y one cause on each lir	the death	. Do not ent	er the mode	of dyin	g, such as	cardiac (	or respiratory a	irrest,			Approximate Interval Between Onsetand Death
2	Priysician		Immediate Cause (Final disease or condition	a asx	m	atro	~	10	ne	em	unc	a			dup
	/Medical Examiner		resulting in death)	Due to (ords	a consequ	ence of):		1							1
į,		-	Sequentially list conditions,	b. Due to (or as	2 000000011	ience of):								-	
$\overline{}$	ted nsit	nine	Sequentially list conditions, if any, leading to immediate name. From the anyling Cause (Disease or injury that initiated events	200 10 (01 00	a consoqu	ionos ory.								- 10	
_^	eath certificate be executed attending physician and for use as the bunat-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ience of):								-	
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.89	ifficat g phy as the	edi													
Вох	death certifica e attending ph ed for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth			∃Ectopic pre	anancy				2	3d. Date o		,
œ.	9 0 0	Physician/M	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐Unknown			Other (spe						Month		Day Year
P.O.	at the 1 by th stach	Phy	9 Unknown								22 0:4				
	The taw requires that the dei tte has been signed by the a page 2 should be detached fo	by	Part II. Other significant conditions			-	nderlying ca	ause give	en in Paπ i.			Yes 2	/		ne cause of death?  ably 4 □Unknown
ord	w require been si should b	ted	alzkeim	us de	men	un					1				
Vital Records,	a faw nas b e 2 sl	Completed									24a. Was		pric	re auto or to cou oth?	psy findings available mpletion of cause of
E E	(0				_						1 ☐ Yes	2 No			2 □ No
VIII.	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only				
ot	this ald	. To	1 ☐ Yes 2 ☐ Mo 27. Manner of Death	1 ☐ Inpatie		ER/Outpatien 28b. Time of		A Bc. Injury			me 5 Resi				v)
	ng fter	tion	1 → atural 5 Pending	(Month, Day	y Year)	Injury	M	Work	ເ?ີ Yes 2⊡I		Lou. Describe	now injury	00001100		
Si	Attanding r death. actor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be Goo Blace of Inju	urv - At ho	me, farm, str					28f. Location (	Street and	Number	or Aura	Il Route Number,
Division	after Dira	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify	)	,,	,			City or To	wn, State)			
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		29a. Certifier 1 Certifying F	Physician: To the best	of my knov	wledge, death	h occurred a	at the tim	ne, date an	d place,	and due to the	cause(s)	and mann	er as s	tated.
	na Ho 24 h na Fu netely	edicai	(Check only 2 Medical Exp	aminer: On the basis of and manner sta	f examinati ated.	ion and/or in	vestigation,	in my op	oinion, dea	th occurr	ed at the time,	date and	olace, and	d due to	the cause(s)
	To the vithing To the Comp	Ž	29b. Signature and title of certifier				29c	- /	e number						Day, Year)
)			1 Will	a	be	20		1)	26	49	19	7	-30	0-	07
	3		30. Name and ddress of person wh				-								and Mercan
	V		Ronald E. Mill 31. Date filed (Month, Day, Year)	32. Registra				Mt.	. Air	y, M	arylano	1 217	71		
	Sta Registr		AUG 0 3 200	7 September	13.	ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1134 AM WATERS July 2007 IASON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 1948 Maryland 59 11, 219-46-1030 Apr. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location Sinders a varies of the marked other than "natural", or items 23a or 28a-f show in marked other than "natural", or items 23a or 28a-f show imarke event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland | Frederick Thurmont 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21788 15339 Kelbaugh Road U.S.A. filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married X Married 1 ☐ Yes 🎾 No Specify: Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warden Prison permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mason Waters Margaret Kline ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Olivia Myers / Wife 15339 Kelbaugh Road, Thurmont, Maryland 21788 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 7/23/07 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. THURMONT, MD 21788 615 EAST MAIN ST., Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) BESPIRATORY 20 min FAILUKE **Physician** /Medical Due to (or as a consequence of): Examiner ARDIAC TUMON EXCISION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CALCINOMA be executed burial-transit KENAL CELL and Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 2 No 1∐ Yes 2√ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural
2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

State Registrar

TREVOR 31. Date filed (Month. 2007

29b. Signature and title of certifier

600 N. Wolfe St, Baltimore MD ELLISON egistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Herr 23a) (Type, Print)

29c. License number

RES-OOC

29d. Date signed (Month, Day, Year)

2007

July

			For State Registrar		State	of Maryla	and / Depa <i>Ce</i> l	artment of H	lealth and Death	Mental Hyg	giene 2	007		55
			Decedent's Name (First,	Middle, La	ist)					2. Date of Dea Month		Year	3. Time of De	eath
	Physicia /Medic	_	Verna Lee	Wats	on					July	21	2007	0440	М
	Examin	- 1	4a. Facility Name (If not ins						or Location of De			ounty of Death		
	\$ X	* .	Carroll Hos						tminster			Carrol		
	Funeral		5. Social Security Number	1	Sex 1 □ M 2 <b>⊠</b> F	7. Age (In y	vrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	Hours Mi		n V. Year) 15 103	9. Birthi	place (State or F ntry) VA	-orei <b>g</b> n
	Director	}	215-34-1858 Usual Residence of Decede	ent			/1			outy (	13 193	00	VA	
	yland		10a. State 10b. C	ounty		10c.	City, Town or Lo	ocation					10d. Inside City	Limits
	9 Mar	ctor	MD	Carr	o11		West	minster					1 ☐ Yes 2	X No
	or 28	Oire	10e. Street and Number					10f. Zip Code				n of What Cou	ntry?	
	ath w	by Funeral Director	414 Poole R	oad	Т2				1157			JSA		
	er de	nue	11. Marital Status	7.44	Armed F		n U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14.	Race - Ameri Black, White,		
5	rs aft	JY F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		If Yes, G Year or	2 <b>∏</b> No live Dates:		1□ Yes 2□No	Specify:		Sp	ecify: Wh	ite	
3	tura stura	ed	15. De	cedent's E	ducation		16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/In		
2	hin 72 In "nu Media	Completed	(Specify only Elementary/Secondary (0	highest gr	ade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	vorking				
7	giene grane	E O	8	,-,2,		(1-401 5+)	H	ousekeep	er		Do	mestic		
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itame 23a or 28e-f show sumatic avant, the Medical Examinar must be multified at	Be (	17. Father's Name (First, M		1)					lame (First, Middle,				
y	buid b Ment arked atic a	P	Lawrence L	yons					Pri	ntie Ques	senber	ry		
_	2 sh and is m reum		19a. informant's Name/Rei	ationship	(Type, Print)					Rural Route Numbe				
ט	s 1 and 2 should be filed within 72 hours after death with the Marylan felled that had been all tygines the marked other than "natural", or tame 23a or 28e-f show then 21 a marked other than "natural", or tame 23a or 28e-f show other treumatic avant, the Modical Examinar mant be motified at		Brenda Andr	ews/D	aughte:	201	164	W. Main	Street	#3 West	minst	cer, MD tion - City or T	21157	
	Pages nent of h int: if its iry or of		1 Burial 2 Crem					nsition (Name of matory or other plants)  Memoria		2472007		ıksburg		
	it. Partmer intent injury		4 Donation 5 Ot  21. Signature of Funeral							-			עניין ,	
<u>a</u>	permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trei		21. Signature of rundian	and the	1300	_				ome and Cl bad Westr			21157	
黎	To the Hospital or Attending Physicien: The law requires that the death certificate be executed to the within 24 bours after death.  The state of the Funetic Director: After this certificate has been signed by the attending physicien and the properties of the funetic Director. After this completely filled in by the funeral director, page 2 should be detached for use as the burial-transit to be united to the funeral director.	Medical Examiner	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions tank and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. List only	b. Due to	each line.  o (or as a con: o (or as a con: o (or as a con:	AS sequence of): sequence of):	1+P	ig, such as caru	ac or respiratory an	1951,		Approximate Interval Betwe Onset and De	ath
.c.	irres that the death certific signed by the attending p d be detached for use as	hysician/Me	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live	utcome of pre birth 2  F gnant at time on nown	Fetal death 3	Ectopic pregnanc Other (specify)	у		230	d. Date of deliv Month	ery Day Ye	ar
,	as tha	by P	Part II. Other significant co			death but not	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use	contribute to t	he cause of dea	ath?
3	w require been sig	ed	RENAL	FAIL	URE					1 🗆 1	/es 201	No 3□Prol	bably 4 ∐Uni	known
וומני	The law nate has be page 2 she	Completed										24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings av impletion of cau 2  No	ailable ise of
ַ בַּ	cien: ertific ictor,	Be (	25. Was case referred to mexaminer?	nedical						eath Check only o	ne)			
-	hyei this o	၉	1 ☐ Yes 2 Z No				2 EP/Outpatier	" JOOK		Home 5 Resid			fy)	
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2	after Direction by	Certification:	4 Homicide	determined	buile	ding, etc. (Sp.	ecity)	reet, factory, office		City or Tox		valliber of rial	a) / louie / ullibe	,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2	edicai C			miner: On the					ice, and due to the courred at the time,				
	o T kith I	Ψ	29b. Signature and title of	certified	· 1	afo	M.D	29c. Licen:	se number		29d. Date s	signed (Month,	Day, Year)	
1	5		30. Name and address of p			- 111		Print)	WESTMIN	USTER MD	211	157		
ling's	Sta	ite	31. Date filed (Month, Day,	Year)	_									
	Registr	rar	JUL 2	4 200	1 Place	in h	J. Apa	W						

			_ FOI	State of Maryla	•			lental Hyg	giene	
			1 - State Registrar		Cer	tificate of	Death		Reg. No	06162
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medic	al	Doris Gloria  4a. Facility Name (If not institution, give st		Welter		r Location of Death	07	19 2007 4c. County of Death	9:30P M
		3	Talbot Hospic			Easto		O Data of Disab	Talbot	Land (State of Foreign
	Funeral Director		133-14-8887	7. Age (in yrs	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	7, Year) 9. Birtr Co. -1923 N. Y	place (State or Foreign intry)
	land		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	ation				10d. Inside City Limits
	Mary a-f sh	to	Md. Talbot		Easto	n				1 Yes 2 No
	or 28	Direc	10e. Street and Number	-		10f. Zip Code	1	1	10g. Citizen of What Co	antry?
	eath w	eral	9115 Honeysuck	Le Drive  . Was Decedent Ever in I	IIS 13 W	2160°		ecify Yes or No-	USA 14. Race - Amer	ican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "natural", or itema 23a or 28a-f show appring or other traumatic event, the Medical Examinational Demotified at ance.	y Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 🌠 Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	
9	2 hou	ted	15. Decedent's Educa	ition	16a. Deced	ent's Usual Occup	pation		White 16b. Kind of Business/I	ndustry
21215-0036	ithin 7. le. len n	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	(ind of work done IO NOT use retire	during most of work d)	ing		
2	filed wi Hygien other th ant, the	S	12 17. Father's Name (First, Middle, Last)		Hom	emaker	18 Mother's Nam	e (First Middle	Own Home	
anc	d be fi	To Be	William Patrick	Travers				Jackso	•	
Maryland	2 should and Men is marke aumatic	Ĕ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street			r, City or Town, State, Z	ip Code)
	and 2 ealth a n 27 is		Kim Welter /	Daughter- in-law	547	4 Well:	ington-D		appe,Md.	
altimore,	Pages 1 nent of Hi ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispos cemetery, crem	ition (Name of atory or other plac	ce)	Date	20c. Location - City or 7	
<u>=</u>	permit. Pag Department Important: I any injury o		* 4 □ Donation * 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Ca	pital	Cremeto	ory 07-2	0-07	Dover, De.	
Ba	Depa Impo any i		Mmmie	Show					Smtih Fune Mdaryland	
			23a. Parti. Enter the disease, or complic shock, or heart failure. List only one						_	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Endo	me-to	ial C	arcinov	na		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
		er	Secuentially list conditions, b. if any, leading to immediate	Due to (or as a conse	equence of):					
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760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
$\infty$	physic properties	dlcal	d.					<del>-</del>		
9 X0	leath certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregr			William		23d. Date of deli	very
о. В	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (s <i>pecify</i> ) _	<i></i>		Month	Day Year
Ω.	es that igned by be deta	by Ph	Part II. Other significant conditions cont	ibuting to death but not re	esulting in the un	derlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ıds	w requires been sign should be	ed b	Colon Cancer,	(Sivens+	Cance	r, H,	pertens	1 🗆 Y	es 2 □ No 3 □ Pro	obably 4 Onknown
Records,	ne law re has be ge 2 sho	Completed						24a. Was a autop	sy prior to d	topsy findings available ompletion of cause of
	: The cate h	Con						perfor	med? death? 2 Ano 1 Yes	2 🗆 No
Viital	Phyaician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1 ☐ Inpatient 2 [	☐ ER/Outpatient	all pos Oth	26. Place of Deat		ne) ence 6 km ther (Spec	16. 11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
0	g Phys er this eral di	Η,	27. Manner of De th	28a. Date of Injury (Month, Day Year)	28b. Time of	3☐ DOA 28c. Injui	4 Li Huising He		ow injury occurred	HESPICE
ion	Attanding I at death. ector: After by the funer	atlo	1 Natural 5 Pending investigation	(World, Day Year)	Injury		Yes 2 □No			
Division of	al or Attana s after death il Director; od in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office		28f. Location (S City or Tow	itreet and Number or Ru m, State)	ral Route Number,
	To the Hospital or Attanding Phyaician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		cian: To the best of my kr er: On the basis of examinand manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	- /	,	29c. Licens	e number	2	29d. Date signed (Month	n, Day, Year)
			) ( Xtx _	>4	enton W	D 1	47492		7/20	2007
	7		30. Name and address of person who con	pleted cause of death (Ite		Print)	of his	F	71. L/X	211.11
	Sta	te	31. Date filed (Month) Pay, Nearl 200	32 Registrar's Sign	nature	you	UB IX.	LASI	UN, MID	21001
	Registr		JUL 2 0 200	Elegue	B. L.	and a				

DHMH 17 Rev 1/2001

07-05370 Roy A. Wriaht. Jr.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

y A. Wilgitt, o		- For State Cert Legistrar Cert	ificate of Death	Reg. No.	2007 2515
Physicia	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day	3. Time of Death Year 1345 hrs
edical Exami		ROY ARNETT WRIGHT, JR		July 13, 2007	
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Bozman	Talb	ounty of Death
		7751 Bozman Neavitt Road			YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.		Foreign
Director		172-22-8349   1XM 2 F   78	Yrs.	MAY 23,192	9 Country) PA
		Usual Residence of Decedent			10d. Inside City Limits
, amy		10a. State 10b. County 10c. City, 7	Fown or Location		1 Yes 2 X No
and show	៦	MD TALBOT	BOZMAN		
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
the N a or	늅	7751 BOZMAN NEAVITT ROAD	21612		USA
with ns 23	raj	11. Marital Status 12. Was Decedent Ever in U.S.	<ol> <li>Was Decedent of Hispanic Origin? (Speff Yes, specify Cuban, Mexican, Puerto I</li> </ol>	, ,	Race - American Indian, Black, White, etc.
leath r iten	Funeral	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No		didarr, etc./	
after al", o	by F	Widowed 4 XDivorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		ecify: WHITE
hours aft natural? Examine		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retir		d of Business/Industry
72 h ra "n sal E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	ů -		D A NIZTNI C
5-0036 led within 72 Hygiene. other than the Medical	ompleted	12 4	VICE PRESIDENT		BANKING
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	၂ပ	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Su	mame)
21215-003 uld be filed withi Mental Hygiene, marked other tl	Be	ROY A. WRIGHT	19b. Mailing Address (Street and Number or R	M. TWILLY	or Town State Zin Code)
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland non to f Health and Mernal Hygies in the Maryland and 11. If then 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	ပ	19a. Informant's Name/Relationship (Type, Print )			
MD nd 2 sho alth and m 27 is aumat		WILLARD C. PARKER II, PER. REP.	129 N. WASHINGTON ST.		cation - City or Town, State
re, slar fred Frite rer tr		4 Division 2 VCremetics 2 Permoval from State	rematory or other place)		
MO Page nent c		4 Donation 5 Other Specify:	ESAPEAKE CREMATION CTR		
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and W. Important: If item 27 is minjury or other traumatic.	1 8	21. Signature of Funeral Service Licensee	22. Name and Address of Facility FELLOWS, HELFENBE 200 S. HARRISON S	IN & NEWNAM	FUNERAL HOME PA
E E E C	17	SIGHO R. MERCERON	200 S. HARRISON ST	C., EASTON,	MD 21601
Physician		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or	r respiratory arrest, shock	Detween Onset and
M_dical aminer;	000	Immediate Cause (Final disease a. Hypertensive Atheroscle	erotic Cardiovascular Disease	E	Death
allillei		or condition resulting in death)  Due to (or as a consequence of	f):		
		Sequentially list conditions, b.	n.		
	Examiner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	0.		
	шa	(Disease or injury that initiated events resulting in death) Last	f):		
cecuted		d			
O, e be exer ysician a	Medical	UNPENDED AMENDED			
760, cate be ex physician he burial	Me	IF FEMALE: 23c. If yes, outcome of pregi			Date of delivery
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of de	2 Fetal death 3 Ectopic pregna	incy M	lonth Day Year
Box 687  e death certific  the attending	sic	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)		
that the death certificate by the attending detached for use as:	Physician	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?
, P.O ires that i signed b	<u>\$</u>		•	1 Yes 2	No 3 Probably 4 V Unknown
S, I quires en sig	ed	·		24a. Was an	24b. Were autopsy findings available
ords, w requir	를			autopsy performed?	prior to completion of cause of death?
Lecc The lay ate ha	Completed			1 Yes 2 No	1 Yes 2 No
tal Rec cian: The L certificate l	B C	25. Was case referred to medical	26.Place of Death (Check		
Vita yslciu yslciu direc	0	examiner?  1 • Yes 2 No Hospital: 1 Inpatient 2	210000000000000000000000000000000000000	-	ce 6 Other: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  The above the signed by an incremental procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of the procession of t		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury	y occurred
on sath.	<u>ē</u>	1 V Natural 5 Pending	1 Yes 2 No		
IVISION Or Attend after death. Director:	≝	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	ome, farm, street, factory, office building, etc.	28f. Location (Street and or Town, State)	d Number or Rural Route Number, City
Div pital o ours af teral D	1 75	4 Homicide determined (Specify)			
Hosp 24 hor Fune		29a. Certifier 1 Certifying Physician: To the best of my knowled	ige, death occurred at the time, date and place, and	d due to the cause(s) and	manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occurred	at the time, date and place	e, and due to the cause(s)
<u>∓</u> ₹ 8	ĕ ĕ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
		and his mo	O.C.M.E.	July '	14, 2007
	1	30. Name and address of person who completed cause of death (Iten	n 23a)		
		Ling Li, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21201		
	State	31. Date filed (Month 104y, Year) 7 2007 32. R distrar's Signat	ure		
	stra		AT ASSESSED.		

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mic	Ce	rtificate of		-	Reg. No. 2. 0 0	7 25158	
13	Physicia	an	1. Decedent's Name (First, Middle, Las	rt)				2. Date of Dea Month	Day Year	3. Time of Death	
	/Medic	_	Hsia-Yu Wang			4h Cit. Tours o	- Location of Dooth	July 2	0, 2007 4c. County of De	3:00 P M	
	Examin	er	4a. Facility Name (If not institution, give 11401 Tulip Popla:				r Location of Death				
\$11	Funeral	E Control	5. Social Security Number 6. Se	ex 7. Ag	e (In yrs. last birthday,		If Under 24 Hrs.	8. Date of Birt	Montgome 9. B	irthplace (State or Foreign	
	Director		217-59-7745	□ M 2 🛣 F (	Yrs.	Months Days	Hours Min.	0ct 28	9. B y, Year)	China	
	/land ow at		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	a-f sh	ctor	Maryland Montgome	ry	Germanto	wn				1 ☐ Yes 2X No	
	iff the or 28	Oire.	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?	
	ath w	ra	11401 Tulip Popla			20876			Taiwan	nerican Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 █ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	ever in o.s. 13.	was Decedent of F If Yes, specify Cub. 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity res of No Rican, etc.)	Black, Wh		
2-0	72 ho 'natur dical	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	edent's Usual Occup e kind of work done	pation during most of work d)	ing	16b. Kind of Busines	s/Industry	
121	should be filed within nd Mental Hygiene. marked other than " ımatic event, the Mer	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	i+)	<i>DO NOT use retire</i> memaker	d)		Own Home		
Dd 2	e filed Il Hyg other rent, 1	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)		
/lar	should be and Mental marked o	10 E	Zheng-Haw Wang				Guei-Yi		<u></u>		
, Maryland 21215-0036	1 and 2 should be a Health and Mental Health and Mental em 27 is marked oother traumatic eve		19a. Informant's Name/Relationship (7 Jia-Shuo Teng/ So		e. Print)  19b. Mailing Address (Street and Number or Rural Rou 6807 Falstone Drive, Fred						
Baltimore,	permit. Pages 1 and Department of He Important: If item any Injury or oth once.		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		Metropo Crem	osition (Name of ematory or other pla litan atory	2007			, Virginia	
Balt	permit. Departimports any Inj once.		21. Signature of Funeral Service bicen	isee	.   2	22. Name and Addre			eral Home, burg, MD 2		
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear failure. List only one cause on each line.  Immediate Over Find disease or condition  Cardiovascular Accident  Approximate Interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and interval Better Onset and Donot enter the mode of dying, such as cardiac or respiratory arrest, and arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arrest or arres								
	/Medical		resulting in death)	a.  Due to (or as	a consequence of):						
	Examiner	L	Sequentially list conditions,	b	es Melliti	S				Twenty years	
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hyperte	a consequence of):					Twenty years	
,	execu n and al-traı	Examiner	that initiated events resulting in death) Last	c	a consequence of):					, ,	
68760,	tificate be executed ig physician and as the burial-transit	Medical		Hyperch	nolesterol	emia				Twenty years	
	rtifica ng ph as th	Nedi	IE EEMALE.								
P.O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delivery Month Day Year		
	w requires that been signed b should be deta	by	1   Ves 2   The							to the cause of death?  Probably 4 ☐ Unknown	
Records,	sician: The law red s certificate has bee irector, page 2 shot	Completed						24a. Was auto perfo 1∐ Yes	psy prior to prmed? death		
ita	lysician: The iis certificate hadirector, page	BeC	25. Was case referred to medical examiner?				26. Place of Deat				
> >	> .9 0	인	1 ☐ Yes 2 ☑ No		ent 2 ER/Outpatie	SIK SEL DOX			dence 6 □Other (S	pecify)	
n C	ling I. After fune	ion:	27. Manner of Death  1X Natural 5 □ Pending	28a. Date of Inju (Month, Da		Wo	ryat rk? ]Yes 2∐No	28d. Describe	how injury occurred		
Division or Vital	or Attendifter death Director: in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj	ury - At home, farm, s c. (Specify)		7103 2 110	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,	
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Co			f examination and/or				cause(s) and manner date and place, and c		
	<b>Го the</b> within <b>Го the</b> хотры	Me	29b. Signature and title of certifier	2		29c. Licens			29d. Date signed (Mo	onth, Day, Year)	
1	0		1 felvice	dus	_	D	3496,	8	July 21,	2007	
	J		30. Name and address of person who H. Victor Chiang,	M.D., 970	7 Medical	Center D	rive, #32	0, Rock	ville, MD	20850	
	Sta Regist		31. Date filed (Month, Day, Year)  JUL 23 2	32. <b>Pegistr</b>	rar's Signature	barte					

Baltimore, Maryland 21215-0036

			For State Registrar	State of	f Marylan		irtment of H tificate of L			giene Reg. No.	71 7	05150
		Я	Decedent's Name (First, Middle,	, Last)					2. Date of Dea	ith	· · · · ·	3. Time of Death
	Physicia	_	Christine Hea	artfield		West			July 16		Year	7:45 A M
4	/Medic Examin	1500	4a. Facility Name (If not institution,		mber)		4b. City, Town, or	Location of Death	,	4c. County of	of Death	7.1.5
1			Potomac Valley N	Nursing Ho	ome		Rockvill	e		Montgo	omery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	Y. Year)	9. Birthpla	ace (State or Foreign
	Director		577-34-0040	1   W 26   F	80	Yrs.			Oct. 17	, 1926 N	1aryl	and
0.70	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	farylan show ed at	ō				D 1 1						1⊠Yes 2□No
	the N 28a-1	Director	Maryland   Montgo	mery		Rockvi	10f. Zip Code			10g. Citizen of W	hat Count	ry?
	with la or t be			* 11 5						U.S.A.		
	death ms 2% mus	Funeral	1235 POtomac V	12. Was Dece	edent Ever in U.	S. 13. V	20850 Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		- America	
(0	r iter	Ē	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	No No				Rican, etc.)		k, White, e	tc.
03(	ours a ral", o Exan	by	3 🗷 ₩idowed 4 🗆 Divorced	If Yes, Giv Year or Da	ve ates:		I∐Yes 2⊠XNo	Specify:		Specify:	Whi	te
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of work	ring	16b. Kind of Bus	siness/Indi	ustry
2121	12 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic event, the Mec	ďμ	Elementary/Secondary (0-12)	College (1	i-4or 5+)			)				
2	led w lygie her tl nt, th	S	12 17. Father's Name ( <i>First, Middle, L</i>	l aat)		L E	lomemaker	18. Mother's Nam	a (First Middle	Ownh		
Maryland	ntal H ed ot ed ot	Be									,	
Ž	hould d Me mark matic	မှ	Maurice K. Hea		1	19h Mailin	g Address (Street a			e Mackal		Cade)
Ma	d2s than than 17is trau		Maurice K. Hear				Boxwood					,
	ges 1 and 2 should be filed within 72 hours after death with the Mar tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sh or other traumatic event, the Medical Examiner must be notified		20a. Method of Disposition	crieru, o		lace of Dispo	sition (Name of natory or other place	DK.Detile	Date Fia	20c. Location - 0		
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State			!	- 22 07	TT 1 .		D 0
Ħ	permit. Page Department of Important: If any injury or once.		21. Signature of Fyneral Service I		I Ua	22	Cemeter:	$y : July$ is of Facility $J_{0}$	seph Gaw	ler's So	ons I	nc.
ä	permit Depar Impor any ir once.		Willwin	R. Bu	MAL	51	l30 Wisco	nsin Ave.	. NW Was	hington		
	4		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that c	caused the death	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		monia							Onset and Death
	/Medical		resulting in death)		(or as a consequ							
8	Examiner		Sequentially list conditions	b			e Pulmona	ry Disea	se			
	p #	iner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	Cue to I	(or de d consequ	uence of):						
	ficate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	C	(or as a consequ	uence of):						
60,	be ex cian a	a E	,	Due to	(or as a consequ	dence oij.						
68760,	ficate physics the	edical		d								
			IF FEMALE:	23c. If yes, ou	tcome pf pregna	ancy				23d Date	e of deliver	rv
Вох	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		oirth 2 🗆 Feta nant at time of d		Ectopic pregnancy Other (specify)	,		Mor		Day Year
P.0.	that the de sed by the a detached f	ıysi	9 Unknown	9□Unkn	own							
	The law requires that the death certi te has been signed by the attending tage 2 should be detached for use a	by PI	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contri	ibute to the	e cause of death?
ď	w require been sig should b	q pe	Stroke						1 🕱 🖰	res 2 □ No	3 ☐ Proba	ably 4 □Unknown
or Vital Records,	aw requisible been 2 should	Completed	Throat Cancer						24a. Was	an 24b. V	Vere autor	osy findings available npletion of cause of
Ä	The lav	mo	Bladder Cancer						perfo	rmed? d	leath?	
ita	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?				115	26. Place of Dear	th (Check only o	ne)		
<u> </u>	Physician: r this certific ral director,	To	1 ☐ Yes 2 No	Hospital: 1 🗆	Inpatient 2□	ER/Outpatier		4 Mursing H	ome 5 🗆 Resid	dence 6 □Othe	er (Specify	)
0	ng Ph After th Ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Worl		28d. Describe I	now injury occurre	ed	
Sio	Attending r death. ector: After by the fune	cati	2  Accident investig 3  Suicide 6  Could n	ation				Yes 2 □ No	004  tion (	24	D	I Davida Aliverban
Division	or At after d Direc in by	Certification:	4 Homicide determi	inod Zoe. Flace	ing, etc. (Specif	y)	eet, factory, office		City or Tov	Street and Number vn, State)	ar or nurar	noute Number,
	pital ours a ceral I		29a, Certifier 1 🔀 Certifyin	g Physician; To the	hest of my kno	wledge, deat	h occurred at the tir	me, date and place	and due to the	cause(s) and ma	nner as st	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		Examiner: On the b								
	To the within To the Somp	Me	29b. Signature and title of certifier		A	IAI	29c. Licens			29d. Date signed		
			1 506	-15944	901V	MIS	200	06243	5	7/1	6/2	2007
	10		30. Name and address of person									
			Sayad Elsayyad N					Rockvil.	le, MD 2	0850		
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 23	2007	Registrar's Signa	ture for	will.					

DHMH 17 Rev 1/2001

			Amend Itemse 234 Maryland / Dep 1- State 19b, Pt I, 25,2	artment of Health and 28a-f per me 88 rtilicate of Death 88	Mental Hygi <b>70,08/02/</b> 0	ene D7dhb per FH/DR
Ī	Physici		1. Decedent's Name (First, Middle, Last)  VANESS A F WICLIA		2. Date of Death Month	
Service Services	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
			Anne Arundel Medical Center	Annapolis		Anne Arundel
I	Funeral Director		5. Social Security Number  6. Sex  1 M 2 7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hr.   Months   Days   Hours   Min	. (Month, Day,	Year) 1956 9. Birthplace (State or Foreign Country) Marvland
	De ,		Usual Residence of Decedent		1,001.	1550 Haryrana
	death with the Maryland me 23a or 28a-f ehow rmast be notified at	Director	10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits 1 Ma Yes 2 □ No
	28a-f		Maryland Anne Arundel Arnold	10f. Zip Code	10	
	3a or	Ö	910 Rock Dove Court	21012	10	g. Citizen of What Country?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. †3.	Was Decedent of Hispanic Origin? (	Specify Yes or No-	USA 14. Race - American Indian,
30	2 hours after death with the Marylan atural; or iteme 23a or 28a-f ehow sal Examiner must be notified at	by Fur	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	If Yes, specify Cuban, Mexican, Puè 1 ☐ Yes 2 疑 No Specify:	rto Rican, etc.)	Black, White, etc.  Specify: Black
2-003b	72 hou		15. Decedent's Education 16a. Deci	dent's Usual Occupation	10	6b. Kind of Business/Industry
7	within 7 ene. than "r	Completed	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wo DO NOT use retired)	orking	
7	iled w tygier her th	S		eral Investiga		<u>Federal Government</u>
all	d be fi	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	,
2	should nd Me mark mark	2	Leroy C. Earley  19a. Informant's Name/Relationship (Type, Print)  19b. Mail		retta Ph	elps Airmapo sas zip Code) 21403
Ž	alth a		Christina Williams (Daughter)	3359 Thomas Po	int Rd.	Annapolist Md. 21
e e	ges 1 a it of He if itam or othe		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State  20b. Place of Disposeretry, cre-	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State
Ě	Pa Imen tant: jury			rematory 6/1	3/07 B	altimore, Md.
Dal	permit Depart Impor any in			2. Name and Address of Facility Wm. Reese & So: 821 West St. A	ns MOrtu	ary, P.A., Md. 21401
Ħ			23a. Part 1. Enter the disease, of complications that caused the death. Do not en	821 West St. A ter the mode of dying, such as cardia	nnapolls  c or respiratory arres	st. Approximate
	Physician		shock, or heart failure. List only one cause on each line.  frimediate Cause (Final disease or condition  Approach of the cause (Final disease or condition)	Oner in sour		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	- 0	. /	300
	_xaniiiici	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of);	gly cenne on	an don	yel 3 ide
	uted ansit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	wen w	isgulfin e	Alexander Hoten 3
ĵ	an an irial-tr	Exa	resulting in death) Last Due to (or as a consequence of):	1/2	ADDROV D BY ME	(CISIM)
0	icate be executed physician and s the burial-transit	dicai	d	CERTIFICAT	TO THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF TH	1100
		<b>a</b>	IF FEMALE: 23b Was decoded program 23c. If yes, outcome of pregnancy		Thous.	
	death atten	Physician/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)	0	23d. Date of delivery  Month Day Year
	tt the c by the tachec	hysi	9 ☐ Unknown 9☐ Unknown			
ń	uires that the death certific signed by the attending p d be detached for use as	by P	Part ff. Other significant conditions contributing to death but not resulting in the	100	23e. Did toba	cco use contribute to the cause of death?
5	requir	eted	PMH Ca BREAST, 3/P 6,	ASINIC BEPASS	1 Yes	2 No 3 Probably 4 Unknown
ב ב	hast nast	Completed	100 M POOR CONTROL,	PMH BIPUNK	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	n: Th flicate or, pag	ပိ	25. Was case referred to medical	DIEASE		death? No 1 Yes 2 No
>	s cert	To Be	25. Was case referred to medical examiner?  1↓ Yes 2↓ 10 Hospital: 1↓ Inpatient 2□ ER/Outpatie	Other	ath (Check only one)	ce 6 ⊟Other (Specify)
5	ig Ph ter thi		27. Manner of Death 28a. Date of fnjury 28b. Time of Month Pay Year		28d. Describe how	
2	tendir eath. or: At the fu	catic	Found Found	A M TOVOS SONS	Unkn	OWD
	or Att	Certification:	3 Suicide 4 Homicide  Suicide 4 Homicide  Suicide 4 Scould not be determined	eet, factory, office	City or Town	et and Number or Rural Route Number, State) Arnnold, MD
			29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal	h occurred at the time, date and place	and due to the cau	Se(s) and manner as stated
	the Ho nin 24 the Fu npletel	Medical	one) and manner stated.	vestigation, in my opinion, death occu	urred at the time, date	e and place, and due to the cause(s)
1	0 v v v v v v v v v v v v v v v v v v v	Σ	29b. Signature and title of certifier	29c. License number		1. Date signed (Month, Day, Year)
1	3)		30. Name and address of person who completed cause of death (ftem 23a) (Type,	Print)	. 1	00113/200/
J	1		MICHAR J. LaPENTA im	441 DEFEN	SE /161	06/13/2007 HWAY ANNAPOUSM,
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	8.0		

			For State Registrar	State of M	aryland		artment o				giene Reg. No.	17	25161
	Physici		Decedent's Name (First, Middle, Grace May Yeage							2. Date of De Month July		) <sup>Year</sup>	3. Time of Death 6:35 A M
}	/Medic Examir		4a. Facility Name (If not institution, Glen Meadows	give street and number,	)		4b. City, Tov		ation of Dea	th	4c. County Balt:		
	Funeral Director		216-62-2261	6. Sex 7. Add 1 ☐ M 2 🔏 F	ge (In yrs. Ia 9	a <i>st birthday)</i> 4 Yrs.	If Under 1 Y Months D		Jnder 24 Hr ours Mir		y, Year)	Cou	place (State or Foreign intry) 11and
	Maryland -f show lied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltir	more		, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 X No
	with the 3e or 28a	Il Direc	10e. Street and Number 11630 Glen Arm	Road			10f. Zip Co 210				10g. Citizen of V United S		*
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified at ODGs.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Nover Married 2 Divorced	12. Was Decedent Armed Forces  1  Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S P No		Was Decedent If Yes, specify		nic Origin? ( exican, Pue pecify:	Specify Yes or No rto Rican, etc.)	Blac	e - Ameri ck, White, /: Whi	
Maryland 21215-0036	d within 72 ho giene. ir then "netur ine Medical I	ompleted	15. Decedent: (Specify only highest Elementary/Secondary (0-12) unknown	s Education grade completed) College (1-4or	5+)	(Give	dent's Usual O kind of work d DO NOT use n emaker	ccupation fone during etired)	g most of w	orking	own ho		ndustry
land	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, L (first name un)		es				Mother's Na Grace	ame <i>(First, Middl</i> e Kirby	, Maiden Suman	пе)	
Mary	nd 2 shouth and N 27 is ma		19a. Informant's Name/Relationsh Alan H. Stocksda		1		ng Address <i>(Si</i> Sussex	_		Rural Route Numb Son, Mar			ip Code)
Baltimore,	Pages 1 and 2 lent of Health a nt: If item 27 is ry or other treu		20a. Method of Disposition  1  Burial 2 X Cremation  4  Donation 5 Other (Sp		, C6	roll C	esition (Name of matory or other cremation	r place) ON		Date y 20, 2007	_	ead,	own, State Maryland
Balti	permit. Departn Importe eny inju		21. Signature of Funeral Service L	censee	M010	72 9	Name and A	ddress of th Ma	Facility E	line Fun reet Ham	eral Hor pstead,	ne Md.	21074
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a:	ine.  Le  s a conseque  a conseque	rolle uence of):				lar d			Approximate Interval Between Onset and Death
P.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent preceant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	d	e of pregna 2 □ Fetal at time of de	ncy death 3[ eath 5[	∃Ectopic pregr ∃ Other (specif	(y)		99a Did	Мо	te of deliveration	very Day Year the cause of death?
Vital Records,	e law requires has been sign je 2 should be	Completed by	At II. Other significant condition	la contributing to death	out not rest	uiting in the u	nderrying caus	e given in	Рап I.	1 🗆 24a. Was	Yes 2 No	3 ☐ Pro Were aut prior to co death?	obably 4 Unknown copsy findings available completion of cause of
/ital	(Q	Be Co	25. Was case referred to medical examiner?						Place of D	1 ☐ Yes eath (Check only		1 🗌 Yes	2 No
Division of V	ing Phys T. After this funeral di	은	1 Yes 2 No  27. M no of Death 1 Natural 5 Pending 2 Accident investig		ury	ER/Outpatie 28b. Time o Injury		Other:  Injury at Work?  1  Yes		Home 5 Res	dence 6 Oth		ify)
Divisi	el or Attendi s after death il Director: A d in by the f	Certification;	3 Suicide 6 Could not determine	ot be 28e. Place of Ir	njury - At ho atc. (Specify	me, farm, st	reet, factory, of	fice		28f. Location ( City or To		per or Rui	ral Route Number,
	the Hospitel nin 24 hours a the Funeral I npletely filled	edical (		Physician: To the bes xaminer: On the basis and manner s	of examinat								
)	To the I	Σ	29b. Signature and title of certifier	Saly	mo			304			29d. Date signe	19,	Loo 7
	V 6		30. Name and address of person w	M C 674	N C	23a) (Type,	es s	1	Bro	TIMORI	y M	0 2	1204
	Sta Regist		31. Date filed (Month, Day, Year)  JUL 2	W/	trar's Signal		South )						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elaine Aaronson Year Month **Physician** 12,208 M 2007 JU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06-02-1929 9. Birthplace (State or Foreign Country) Baltimore 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Funeral Months 1 □ M 2 🗓 F 78 Director 216-24-1210 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r then "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Phoenix Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4003 Mildale Ct 21131 U.S.A. e filed within 72 hours after death if Hygiene. other then "natural", or Items 23 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Š White 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) Agnes Christina Petrich Harry William Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4003 Mildale Ct Phoenix, MD 21131 Patricia Aaronson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) 07-17-2007 Bel Air, Maryland Bel Air Memorial Gar. 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signatur Fyneral Service License Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Physician 91 Theo /Medical Due-to (or as a consequence of): **Examiner** 0 Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the be detached Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No ဥ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death.

Director: Aft
In by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai completely (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title-pf certifier 00061886 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 10

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31. Date filed (Month, Day, Year)

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32 Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deal Year Month **Physician** Aug 1059 2007 /Medical 4c. County of Deal 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bey Mont tresda buyban 8. Date of Birth (Month, Day, Year Sept. 16, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours Min. New York 1 M 2 X F 1917 Director 89 577-36-2350 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Pompano Beach 12 Yes 2 No Florida Broward Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 33069 United States of America 802 Cypress Grove Lane Apt.302 Bldg. 122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Caucasian 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Chassman Julius Cohen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any Injury or other trains #808, Chevy Chase, MD 20815 Dr. Clement Alpert - Cousin 5600 Wisconsin Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/09/07 Hawthorne, New York Eden Cemetery 4 Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility Hines - Rinaldi Funeral Home, Inc 21. Signature of Funeral Service Licenses Silver Spring, MD 20904 11800 New Hampshire Ave. Approximate Interval Between Onset and Death 23a. Powr. Ephr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slifts, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate account of the cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Otner (specify) 9☐Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒️No certificate has 1∐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 1 Natural 5 Pending investigation )e// 16,2007 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 55555 Strents Number, Blue 424 Character Character March 18/5 determined 4 Homicide Assisted De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ August 8, 2007 D53367 Juyamorman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan 20 9801 Georgia Ave, Suite 117, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ZION HOPE, THOMAS, ANDERSON 2:16 PM 27 0 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 20F None USA 07,16,2007 **Director** 0 11 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside Øity Limits or 28a-f show Examiner must be notified at 1 ☑Yes 2 ☐ No MD Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygie Important: If item 27 is marked other it any injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Dominique homas MoThere 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1629 N. BROadway nderson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 07 Arbutus Mem PK 4 □ Doration 5 □ Other (Specify) 21. Signatur of Fundal Sarvice Lansee Broadwa 21213 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUNDROME 23TAESS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tunneral director, page 2 should be detached for use as the burial-transit onnipietely filled in by the tunneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2P No 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy
performed?

Yes 2 \( \subseteq \text{No.} \) 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No ျ 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 0

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Registrar's Signature

Nilu Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
AUG 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend #7, perFH,g870, 8/7/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 7:10 AM ARICHDIY ASVIYAN AUG 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner (LAMMA) HOWARLD WUNTY GONGRUM HUSPITAL COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/26/1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours 1 M 2 □ F UKRAINE 609-60-7842 60 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any ligury or other traumatic event, the Medical Examiner must have the context. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1080 CRADLE ROCK WAY #616 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: 3 Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) REPAIRMAN TELEVISION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARKADIY ASVIYAN DINA VELENSKAYA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANATOLY BRISKIN/SON-IN-LAW 9362-A NEIL ROAD-PHILADELPHIA, PA 19115 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State SHALOM CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 108/06/2007 LOWER MORELAND, PA 21. Signature of Funeral Service Cicenser 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** ANGNOCHRUNOMA 6 MUNTITS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? COROMANU MILTORY DISEASE 1 Yes 2 No 3 Probably 4 Unknown HOURSO CAZGNOWA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♠No 24a. Was an page 2 s autopsy 2 A No 1□ Yes **Director:** After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 ☐ No P 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hos within 24 ho To the Functional (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 1) 36974 AUG 4 20007 30. Name and address of person who completed cause of death (item 23a) (Type, Print) O'NAVADEM WO 10724 UTTIE PATURENT PKINY COLUMBIA My 2124

Registrar

State

31. Date filed (Month, Day, Year)

more

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 1940 PM David James Brandt Sr. /Medical AUGILET 06 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BAUTIMONE BAYVIEW MEDICAL CENTRE JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 15, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1**X** M 2□ F 66 220-36-7257 Director 1940 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1X Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1118 South, East Avenue 21224 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White <u>^</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer 11 General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be John C. Brandt Laura A. Phoebus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Dorothy Brandt, Wife 1118 South East Avenue Baltimore, Marylqand 21224 20b. Place of Disposition (Name of Dufaney, cremators or other place)
Dufaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 08/10/07 Timonium, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes You this certificate has autopsy 20X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 12 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28689 August 07, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Bayweii Medical Center Besimon JOHNS

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month; Day,

Year)

AUG 07

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** ust 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 11 Chris Atome lowson HIMOR 7. Age (In vrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 27, 191 cial Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 2×F -16-9808 ary land Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 □ No Injury or other traumatic event, the Medical Examiner must be notified Director Mary land 10e. Street and Number 10g. Citizen of What Country? or Items 23a or Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Itam any Injury or other traumons. Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 Widowed 4 □ Divorced ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omest1 Grade 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be seorge ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location & City or Town. State 1 Burial 2 □Cremation 3 □F 4 □Donation 5 □Other (Specify) vinas 21. Signature of Funeral Service Licensee vis Fune Keisterstown arrio Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA Physician MEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 Munknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Was ... autopsy performed? Ves 2 this certificate has Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 5 ☐ Residence Specify) HOS FICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DANIEUL DOBERMAN, NO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. agstrar's Signature

6565 NCHAPLES ST. SMITE 216 TOWSON, MD 21204

07-05817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

атопа вен		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No. 2007 2516		
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Rough Pear July 29, 2007  2. Date of Death Month Day Year 1930 hrs		
*		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death		
Funeral	4	Johns Hopkins Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or		
Director		219-80-3898 1 M 2 XF 48 Yrs. Months Days Hours Min. March 29,1959 Foreign Country) Md.		
a market		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits		
Maryland 28a-f show d at once.	ģ	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?		
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director	1919 N. Castle St. 21213 USA		
ath with items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.		
after de	by Fu	3 X Widowed 4 Divorced of Yes, Give Year or Dates:  1 Yes 2 X No specify: Specify: Specify:		
72 hours "natur	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)		
5-0036 led within 72 hours a Hygiene. other than "natural	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Joseph Flord Margaret Haves		
sho and 7 is	유	19a. Informant's Me/Relationship (Type, Pr. t) Sister 19b. Mailing Address (Street and Number Hural Route Number, City or Town, Itate, Zip Code)		
ore, MC es I and 2 st of Health an If item 271 her trauma		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)		
im Pag ment tant:		Burial 2 IX Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility		
Balt permit Depart Impor injury		Joseph L. Russ Funeral Home, P.A. 12222 W. North Ave. Balto, Mg. 21216		
Physician /Medical		23a. Pal-1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.  Approximate Interval Between Onset and Death Death		
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Acute ethanol intoxication and cocaine use  Due to (or as a consequence of):		
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
11/6	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):		
executed in and il - transi	calE	d.  X UNPENDED  AMENDED   760, cate be		#23a,PI1,27,28a-T,DenVIE,g87U, 8723/U/ TT  23c. If yes, outcome of pregnancy  23d. Date of delivery
Box 68760, death certificate be ex the attending physician ed for use as the burial.	ician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)		
the de	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?		
ires that the signed by	ব	Sarcoidosis 1 Yes 2 No 3 Probably 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should to	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death?		
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical 26.Place of Death (Check only one)		
Vital hysician:		examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 Other:		
ion of tending Pheath.		27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  7/29/2007  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 X No unk  28d. Describe how injury occurred unk		
Divisic pital or Atte ours after desertal Directo filled in by the	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town State)		
lospital 4 hours 7 uneral	_	4 Homicide (Specify) residence 1919 N. Castle St. Baltimore, MD		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medica	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  July 30, 2007		
		30. Name and address of person who completed cause of death (Item 23a)		
Sta	i e	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registi	rar	31. Date filed (Nonth, Day, Year) 2007 34 Registrar's Signature		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** рм 2007 8:15 Michael Blanar August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Timonium Baltimore Stella Maris Hospice If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Nov 24 , 1911 171-03-3615 95 Director Pennsylvania Usual Besidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other than "nature". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 Rounwood Road United States Of America 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes No White Specify. Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) Union Worker 8 N/A Long Shoreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Kanyak Michael Blanyar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Gwen Drive ,Forest Hill, Maryland21050 e of Disposition (Name of Date 20c. Location - City of Town, State Carol Blanar-Lader (Daug) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Parkwood Cremetery 4 ☐ Donation 5 ☐ Other (Specify) August 9,2007 Parkville, Maryland EVANS FUNERAL CHAPEL AND CREMATION SERVICES 8800 HarfordRoad Parkville, Maryland 21234 21. Signature of Funeral Service Licenses 1 octuer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** omplications /Medical Du to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a sone squance of) Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No autopsy perform certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1104 Piece of injury - At home, farm, street, factory, office building, etc. (Specify) un Knowly 2 Accident 1 ☐ Yes 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12261 Roundwood Rd. Timonium and 21099 Nomt

To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: filled in by

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

th (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month 8 3 2007 Janet W. Braswell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9024 Scotts Haven Drive Baltimore Parkville 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√5√F 62 Director <u>June 19, 1945 Otaego, Virginia</u> 219-48-0160 Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits Ħ r 28a-f sho notified a 1 ☐ Yes 2 XNo Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e United States "natural", or items 23a o Funeral 21234 9024 Scotts Haven Drive America death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt; If item 27 is marked other than "natural", or ite 1 ☐ Yes ♀☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 【 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygier 27 is marked other the r traumatic event, the Bartender/ Waitress Orchard Landings 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Harmon West ၉ Alfreda Cline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 any injury or other troone. Robert Braswell/ husband 9024 Scotts Haven Drive Parkville, Maryland 21234 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20a. Method of Disposition Date 20c. Location - City or Town, State 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Hill, Maryland Rel Air 21. Sign e Juneral Service License 22. Name and Address of Facility
Peaceful Alternatives. Funeral
2325 York Road Timonium, &Cremation Ctr.,P.A Maryland 21093. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCIWOM **Physician** monch /Medical Due to (or as a consuluence of) Examiner Sequentially list conditions, if eny cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 mon Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Division or Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 2 1 or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Desidence 6 □Other (Specify) this funeral er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

hin 24 hours a within 7

State Registrar 29b. Signature and

30. Name and addr

person who completed cause of death (Item 23a) (Type, Print)

Conti

Towson, Maryland

29d. Date signed (Month, Day, Year)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** BUTT AUGUST 2007 12:46 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Baltimore Center Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕱 F 213-20-8364 Director 9 Marylanc Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be 21234 Funeral )endove 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No \$ Specify: white 3 Widowed 4 Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Ker at Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, t once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kes ornel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) jeonge Burrill 1819 Baltimore Wendover Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 8-7-2007 Parkton, Stablers Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility & Clemation Services-Parkville 8800 Harford Road Parkville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE DAYS /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed DEMENTIA YEARS burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔯 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46356

Registrar

DHMH 17 Rev 1/2001

State

DRIVE

MARY

OSLER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TABASSI.

AUG 0

KHOSROW TABE
31. Date filed (Month, Day, Year)

M. D. 7601 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 10130 AM William Bryson 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bactimore City NA 1633 W. Lexington Street f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Se 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Year) 212-34-8165 12 M 2 ☐ F Yrs. Director 11,1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show than "natural", or items 23a or 28a-f shov he Medical Examiner must be notified at 1 Yes 2 No NIA Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Lexington Street

12 Was Decedent Ever in U.S.
Armed Forces? 21223 Funeral 1633 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ 3 ☐ Widowed 4 ☐ Divorced Black Completed permit. Pages 1 and 2 should be filed within 72 ho Depatrment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturny prother traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Laborer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ruchell BUSON Annie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Citylor Town, State, Zip Code) Sherry R. Moore 1633 W. Lexington St. Baltimore; MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State Mt Zion Cemetery Aug 7, 2007 Lands downer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeval Home Ringed A Grayson Fre Renced Trayer 21229 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with brain metastases Concer **Physician** 416 2 years /Medical Due t () as a consequence of): Examiner Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) a Tilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 

Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed!

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Home Herrice Hospital: 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely f (Check only one) and mapner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 08.02.2007 7 41476 30. Name and address diverson who completed cause of death (Item 23a) (Type, Print)

RAYMOND W. WILSON MP. \$565 N Charles Street, #416, Baltimore, MD 21204-5803

Registrar

30am

<u></u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Aug 3, 2007 Physician Catherine Ε. Beal1 21:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 12, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔽 F 85 Ï921 Washington DC 579 12 6654 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mines and once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Prince George's Director Marvland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8600 Mike Shipiro Drive Apt 908 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White Specify. þ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOmemaker** Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellis Dean Mildred Riurick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Brady (Daughter) 5302 Riga Street, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland 4 Donation 5 Dother (Specify) Lee Crematory Aug 5, 2007 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): OBSTRUTING Pulming Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? res 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician certificate or Attending Physician: this After

signed by within 24 hours after death

To the Funeral Director: completely filled in by the f To the Hospital

State

29a. Certifier (Check only one)

31. Date filed (Month, Day,

29b. Signature and title of confile

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNORMO

and manner stated.

11701 Livingsher Road Fut WASTINGSM Manyland

Registrar DHMH 17 Rev 1/2001 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			For State of Marylar		artment of H r <i>tificate of L</i>		lental Hygi	ene		
	典	ч	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. No.	147	3. Time of Death			
	Physic /Medi		Anne Birkholz					2007	Year	2:50 Ам
0	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
eli	Funeral		Stella Maris  5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday)	If Under 1 Year	monium If Under 24 Hrs.	8. Date of Birth		alti:	more lace (State or Foreign
	Director		092 <b>-</b> 10-9664 <sup>1□ M 2</sup> ☐ 91	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 17	Year) 1915	New	York
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	th the or 28a e noti	Director	10e. Street and Number		10f. Zip Code	7 (3 11)	10	g. Citizen of W	hat Coun	try?
	ath wi		2300 Dulaney Valley Road			21093			USA	
10	fter de ritems Iner n	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Wildowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	- 1	Was Decedent of His If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America , White,	an Indian, etc.
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nd ?	al Hyg I other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name				
A.A.	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n traumatic event, the Medi	ဥ	Casimir Boykow	1			9	rtelik		
50 <b>Ma</b> l	and 2 st ealth and n 27 is n	0.8	19a. Informant's Name/Relationship (Type. Print)  Lorraine Ponsi/Daughter		g Address <i>(Street a</i> Eastridg		d Route Number, imonium			
2: Je,	of Heal		20a. Method of Disposition 20b. I	Place of Dispo	sition (Name of natory or other place	; D		Oc. Location - 0		
ii	Pages ment of I ant: If ite			donna C	emetery	8/9/				ew Jersey
2:50~A.M. Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		. Name and Address		k Towsor			
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	queries of):					- 23	
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<i>c</i> .	w requires that the death certi been signed by the attending should be detached for use a	ysici	1 ☐ Yes 2 ☐ 4 ☐ Pregnant at time of c		Other (specify)			Mon	tn	Day Year
AUGUST ords, P.C	s that the ned by the e detacher	by Phys	Part II. Other significant conditions contributing to death but not res	sulting in the	derlying eause give	n in Part I.	23e. Did toba	cco use contril	oute to the	e cause of death?
IRKHOLZ AUGU or Vital Records,	requires sen sign rould be		Confitted Hist				1 ☐ Yes	2 □ No 3	∃ ☐ Proba	ably 4 Jonknown
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BIRKHOLZ n or Vital F	ysicia s certi directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes  1 ☐ Inpatient 2 ☐	1ER/Outpatien		26. Place of Death			(Cassifu	d
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ANNE B Division	lor At after d Direc	Certification:	4 Homicide determined 28e. Place of injury - At h-building, etc. (Specification)		eet, factory, office	2	8f. Location (Stre City or Town,		r or Rural	Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after fleath.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.		29a. Certifier (Check only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of my know only contact of the best of the best of my know only contact of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the	owledge, death	occurred at the tim	e, date and place, a	and due to the cau	ise(s) and man	ner as sta	ated.
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	<b>70</b> wit	<	29b. Signature and the of certifier	-3. 4	1 Zac. License	ilumber	-	d. Date signed		
	7	}	30. Name and address of person who completed cause of death (Iten	n 23a) (Type. í	Print)					
4			EDDIE NAKHUDA, M.D. 2300 DULA	ANEY VA	LLEY ROAL	TIMONIU	UM, MD 2.	1093		
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signa	ature K. A.						
	3.0		AUG 0 7 2007 /	Pl Rad	14. 1					

DHMH 17 Rev 1/2001

AUGUST 5, 2007

ANNE BIRKHOLZ

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:20 a<sup>M</sup> Ju1y 2007 SAMUEL BURROWS 31 Ρ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Locust Lodge Assisted Living Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M M 2 □ F Months Days Hours 91 Pennsylvania 196-09-5200 March 30, 1916 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hygiene. and: If Item 27 is marked other than "natural", or Items 23e or 28e-f show ant: If Item 27 is marked other than "natural", or Items 23e or 28e-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 1 ☐Yes 2 No Anne Arundel Pasadena Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 184 Meadow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Postal Service College (1-4or 5+) Elementary/Secondary (0-12) 12 Postal Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Paisley Robert J. Burrows 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 is any Injury or other trau Meadow Road, Pasadena, Maryland Martha Burrows 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem.
Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 08-03-07 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA END STAGE YRS Physician /Medical Examiner - TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner tension and Congestion attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♠ No autopsy perform HUPO KaleniA 2 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registra

29b. Signature and title of

and manner stated

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 8:50 ам July 31, 2007 Joyce Binder /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Friends Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖺 F Director 85 077-20-1526 August 17, 1921 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2k No Directo New York Nassau Kings Point 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1 Dock Lane 11024 U.S.A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify. Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker Non Profit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estelle Bass ဥ Abraham Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Dartmouth Avenue, Silver Spring, Maryland 20910 Wendy Binder - Daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Old Montefiore Cemetery 8/2/2007 Queens, New York 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses udewia 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that c. use shock, or heart failure. List only one cause on e. ch Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) Inanition /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease Years Sequentially list conditions, if any leading to immediate Due to for as a consequence of Examiner if any leading to immedi-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan: The law requires that the death certificate be executed 4 months Bullous Pemphigoid burial-trar and Due to (or as a consequence of) physician Physician/Medical Senile Dementia Years as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Cerebrovascular Accident 1 Tes 2 No 3 Probably 4 Dunknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Osteoperosis 24a. Was an autopsy certificate | 1∐ Yes 2 No Hypertension 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25345

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 687607

1731 Briggs Chaney Road, Silver Spring, Maryland 20905

30. Name and address of person who completed cause of peats (Item 23a) (Type, Print)

32. Registrar's Signature

Miller.

John E. Glancy, III, M.D.,

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** William Thomas Bennett 8 3 2007 11:55 ₺ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Health & Rehab Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/14/1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☑ M 2 □ F Country) 67 218-36-4321 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at MD Anne Arundel Linthicum 1 ☐ Yes 2√☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 557 Forest View Road 21090 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Motors Assembler h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Elizabeth Hayes George Earl Bennett Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra once. Mrs. Geraldine Bennett/wife 557 Forest View Rd., Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial 8/7/2007 Dopation 5 Other (Specify) Elkridge 21. Signature 22. Name and Address of Facility Singleton Funeral Home 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Glioblastoma Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to intracdate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deeq detached for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an perforn 25. Was case referred to medical examiner?
1 Yes XNo Be 26. Place of Death (Check only one) Hospital: Other: 4Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier Physician D56950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8094 Edwin Raynor BIVD Sute A Paradena Nnaemeka 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 0 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 10 M Robert Thomas 2007 Bucher UgUST 2 4a. Facility Name (If not institution, give street and number) 4c. County of Death ANNE PASHINGTON MEDICAL ( RUNDEL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7/29/1954 5. Social Security Number Months 1**∑**M 2□ F Min 53 084-44-7523 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes 2√ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7858 Americana Circle 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white

**Physician** /Medical Examine

**Physician** 

/Medical

Director

Funeral

**Examiner** 

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anotes.

Baltimore, Maryland 21215-0036

certificate has been si rector, page 2 should

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

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	Examiner
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-	Certificat
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eted	15. Decedent's Ed (Specify only highest gra	lucation ade completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b. k	16b. Kind of Business/Industry					
To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	\text{life. DO NOT use retire} Administrator	rd)	Dep	t. of Defense					
e C	17. Father's Name (First, Middle, Last,			18. Mother's Name (First	, Middle, Maider	n Surname)					
.0	Donald Bucher			Elizabeth	Lamber	t					
	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailing Address (Street	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	Mrs Jessie Bucher	/wife	7858 American	na Cir.#103 G	len Bur	nie MD 21060					
	20a. Method of Disposition	20b. I	Place of Disposition (Name of cemetery, crematory or other pla			ocation - City or Town, State					
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval hom State	sapeake Cremat:	1 0/1/000	7 Ste	vensville MD					
	21. Signature Funeral Service Lice			ess of Facility Single	ton Fun	orol Homo					
	1 XXX	MO	1364 1 Second A	Ave SW Glen B	Burnie M	D 21061					
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deaf				Approximate Interval Between					
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	resulting in death)	Due to (or as a consec	uence of):	a reactor at the		6 masts					
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ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	juence of):	3							
ani.	that initiated events	C									
Ä	resulting in death) Last  Due to (or as a consequence of):										
<u>Sa</u>		⊾d									
Med	IF FEMALE:										
an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta	ancy al death — 3 □Ectopic pregnanc	v		23d. Date of delivery  Month Day Year					
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Be Completed by Physician/Medical Examiner		una acadelle de de ales acusa de dante o									
þ	Part II. Other significant conditions of	,	76			obacco use contribute to the cause of death?					
ted	Dee	Venous	101 811 65	5/5	1 ☐ Yes 2	Probably 4 Unknown					
ed.				24	4a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
5				1[	performed? ☐ Yes 2 12 No	death? 1 ☐ Yes 2 ᡚNo					
Be (	25. Was case referred to medical examiner?			26. Place of Death (Che							
	1 ☐ Yes 2 ☐ No		ER/Outpatient 3 DOA Oth	ner: 4 Nursing Home 5	Residence	6 □Other (Specify)					
lical Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju Injury Wo	ry at 28d. D rk?	escribe how inju						
cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2 □ No							
ŧ	4 Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, factory, office by)	28f. Lo <i>Ci</i>	cation (Street a. ty or Town, Stat	nd Number or Rural Route Number, e)					
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ca		niner: On the basis of examina	owledge, death occurred at the ta ation and/or investigation, in my			s) and manner as stated.  Indicate place, and due to the cause(s)					
Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	20d Ds	ate signed (Month, Day, Year)					
_	5	1. Oe Tu	un D	24285	250. 06	ite signed (Month, Day, real)					
	( west	Due 1	TO D	24283	<u>(Q)</u>	Ugust I 2001					
	30. Name and address of person who	1 1	1 1 0 -	laries El	1 = 1	LO GEN					
	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ledical lent	er 301 H	tospita	I WIVE BUTHIE					
e	Mic 0 7 2		M. Brash		•						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OV 200 04, 4c. County of Death 4b. City, Town, or Location of Death

**Physician** /Medical Examiner

**Funeral** Director

or 28a-f ehow the Medical Exeminer name by notified at

Director

Funeral

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Completed

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene Important: if item 27 is marked other than "natural", or items 23a any njury or other traumatic event, the Mudical Examinar surresponse.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

physician and the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending pt for use as t ate has been signed by the page 2 should be detached After this funeral of death.

Examiner Be Completed by Physician/Medical Certification: To within 24 hours after death To the Funeral Director: completely filled in by the Medicai

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Bloom Days Hours Min. July 29, Year 941 4a. Facility Name (If not institution, give street and number) (-lize bath Cente N/A Social Security Number 7. Age (in yrs. last birthday, Birthplace (State or Foreign
Country) 1**X** M 2□ F 220-38-8726 66 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 215 Radstock Rd USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Types 2 No 1961-If Yes, Give Year or Dates: 1965 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 1965 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Sheet Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald W. Clarke Ann Callary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Pricharlotte Clarke/Wife 215 Radstock Rd Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) Metro Crematory, Inc. 8/6/07 Balt:
Dring Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) una ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No ensign 1 ☐ Yes 2 ☐ No (4)nevt 1 Yes Was as referred to medical examiner: 26. Place of Death (Check only one) Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 ☐ Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed M

AUG 07

2007

1000

115617 32. Registrar's Signature

cause of death (Item 23a) Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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			For State Registrar	State of Maryland	-	rtment of H			giene	07	25180
Ü		#4.40°	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Olwin Pauline	Clark				A45us	F 06 2	Year	3:25 PM
	Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Deat		4c. County	of Death	
		4 2	Future Care Chesape			Arno1d			Anne	Arun	del
100	Funeral Director		212-12-4511	7. Age (In yrs. last	t birthday)_ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day AUG 27	1920	Coun	lace (State or Foreign try) Land
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Loc	ation				1	Od. Inside City Limits
	fanyl.	ō				4,1011				'	1 □Yes 2X No
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2/20	cate t	dica	<b>d</b>								
O. Box 6	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	If yes, outcome of pregnancy  1 Live birth 2 Fetel de  4 Pregnant at time of death  9 Unknown	ath 3 □I	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ry Day Year
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0	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury Work	at	28d. Describe h			
<u> </u>	tendi eath. or: A the fu	cati	2 Accident investigation			M 1 □ Y	es 2 □No				
DIVISION	of or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined	<ol> <li>Place of Injury - At home building, etc. (Specify)</li> </ol>	, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rurai	Route Number,
	To the Hospital or Attending Physician: The law within 24 bours elfer death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knowled: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the d rred at the time, d	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier			29c. License		t t	29d. Date signed		* * * * * * * * * * * * * * * * * * * *
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. !	2 1	}	30. Name and address of person who comp	pleted cause of death (Item 23	a) (Type, P	rint)	-				-
/			mobil Neg 860	1 VETERENS	Huge	way.	Miller	sville	mi).	2110	8
	Sta Registr	te ar	31. Date filed (Month, Day, Fear) 7 200	32. Registrar's Signature	4 1	poster					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 August 5, **Physician** Cochran PM Rodger Dale 3:13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 602 "C" Carrollwood Road Middle River If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 58 Jan.10,1949 Maryland 202 34 8442 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Exa<u>miner must be notifiled</u> i Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21220 602 "C" Carrollwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Cafeteria Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Vincent Cochran Betty Penson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 602 C Carrollwood Rd. Baltimore, Maryland 21220 Catherine D. Cochran (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. Dulaney Valley Memorial 8/9/2007 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licenses Mm In Þ 1407 Old Eastern Avenue Essex Maryland 21221 rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) io mvo Jath /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 24 | To the Fu and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D44768 AUGUST 6, 2007 Mileur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 568 CARNEGIE, 600 N. WOLFEST. ILAN S, WITTSTEIN BALTIMORE, MD 32. Registrar's Gignature 31. Date filed (Month, Day, Year) State AUG 0 7 2007 Registrar

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	2 ☐ Kertifying Phy 2 ☐ Medical Exam	iner: On the basis and manner:	of examination	on and/or in	ivestigation, in my o	me, date and plac ppinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)	1
To the within To the complete	Me	29b. Signature and	title of certifier				29c. Licens	e number		29d. Date	e signed (Month	, Day, Year)	
		1	/Jal-	- NO.			D33	627		Tulu	31	2007	
		30. Name and add	ress of person who o	completed cause of	f death (Item 2	23a) (Type,		10	1, 1	1,1	1.	11 - 10	111
20	tota	31. Date filed (Mon	SHWALE	PLA MI	strar's Signatu	re Ly	ille lat	exent Pi	my C	e/Um	bia, N	10 210	44
S Regis	tate trar		AUG 0 7 20	(39)	u B	lo	and i		(				

			For Stata Registrar	State	of Marylan	•	artment of I		nd Mei		ene g. No.		251	83
			1. Decedent's Name (First, Midd	le, Last)					2.	Date of Death			3. Time of	Death
	Physicia		Anne	C.	Cromwell	1			А	Month Ugust L	, 2007	'ear	8:24	пΜ
	/Medic Examin		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, Town,	or Location of			4c. County of	Death		_F
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	Eugaral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24	4 Hrs. 8.	Date of Birth			ce (State or	r Foreign
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	the 28a	Je.	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Countr	y?	
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	hours after death with the Maryland jural; or Itame 23a or 28a-f ahow al Examiner must be notified at	Funeral Director	11. Marital Status		cedent Ever in U.		Was Decedent of I	Hispanic Origin	in? (Specif	y Yes or No-	14. Race		n Indian,	
	itan	ᆵ	1 Never Married 2 Mar	ned 1 TYes	Forces?		If Yes, specify Cub	an, Mexican, I	Puerto Ric	án, etc.)	Black,	White, et	c.	
ž	es ii.	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes. 0	Sive		1 ☐ Yes ANO	Specify:			Specify:	Whi:	te	
21215-0036	2 hou	Completed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occu	pation			6b. Kind of Busi	ness/Indu	stry	
5	within 72 ene. than "na! ne Medic	piet		st grade completed		(Give life.	kind of work done DO NOT use retire	during most o	of working					
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2	should and Menis marketer	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street							
Ξ	01 00 = 00		Richard Cromw	ell-son		4 Шіг	ndy Hill	La. li	ulav I ar	nd. MA	01778			
ā,	of Health litem 27 other tr	Ì	20a. Method of Disposition	C11 0011	20b. P	lace of Dispo	sition (Name of		Date		0c. Location - C	ity or Tow	n, State	
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altimore,	permit. Pag Depertment Important: any injury once.	-	*4 Donation 5 Other (S		Į.				· ·					
- Ba	permit. Pages Depertment of Important: If it any injury or o		21. Signature of Funeral Service	Will	liam G. D	)au ''	Name and Address 1050 You	ck Rd.,	Ruck Tows	Towson son, MD	Funera 21204	1 Hor	ne, Ir	nc.
П			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that t only one cause or	t caused the death each line.	n. Do not ent	er the mode of dyi	ing, such as ca	ardiac or re	espiratory arre	st,	1	Approximate nterval Bety	ween
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	death d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	birth 2 Fetal gnant at time of de		]Ectopic pregnanc ]Other (specify) _	;y			Mont	h D	ay Y	/ear
9	at the de by the a	Physician/Med	9 Unknown	9□ Unk	nown									
7	res that igned to be deta	by P	Part II. Other significant condition	ons contributing to	death but not resu	ulting in the u	nderlying cause gr	ven in Part I.		23e. Did toba	acco use contrib	ute to the	cause of de	eath?
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			OF Was assessed to madies						4 B 11 16			Yes 2	□ No	
Vital	certi	Be	25. Was case referred to medical examiner?	Hospital:		50.0	O	her _		Check only one		/m		
ō	Phys ral di	2	1 Yes 2 No  27. Manner of Death		Inpatient 2 1 e of Injury	28b. Time of	IT 3 DOA	4 LENUIS			v injury occurred			
	ding F. After funer	lon	1 Datural 5 ☐ Pendi	ng (Mo	e of Injury onth, Day Year)	Injury	Wo	ork? ]Yes 2⊟No			,			
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Division	or A after Direction	Certification:	4 Homicide determ	buil	ding, etc. (Specify	()	cot, factory, office			City or Town,				,
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	24 h	Medical	(Check only 2 Medical	Examiner: On the	basis of examinat	tion and/or in	vestigation, in my	opinion, death	n occurred	at the time, da	te and place, an	d due to t	he cause(s)	)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certific		ctatodi		29c. Licen	se number		29	d. Date signed	Month, Da	ay, Year)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KEVIN CANNON 0 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wiver 5 ity Of Many land Hospital 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) more Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2□ F Months Days Hours Min. Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits RICHMOND 1 X Yes 2 No Director VIRGINIA RICHMOND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or Items 23a or the Medical Examiner must be r USA 5463 CATTERICK RD. 23234 by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than College (1-4or 5+) Elementary/Secondary (0-12) -12--0-DISABLED DISABILITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I pe WILLIAM G. CANNON ANNE R. REESE Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trau MICHAEL W. CANNON 608 UNION ST. COLUMBIA, MARYLAND 17512 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XI Burial ☐ Cremation 3 XRemoval from State ANDIANTOWN GAP NATL. 8-6-2007 ANNVILLE, PENNA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Server License JONATHAN D. HIBNER Name and Address of Facility CLYDE W. KRAFT FUNERAL HOME, INC. 519 WALNUT ST. COLUMBIA, PENNA. 17512 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirting, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseased condition resulting in death) **Physician** Caraconyora 3 years /Medical Due to (or as a consequence of): Examiner 200 Glass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, CERTIF by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 s autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner?
1 X Yes 2 No 26. Place of Death (Check only one) Be Other: 2 1 Mpatient 2 ER/Outpatient 3 DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) neral Director: After the filled in by the funeral 28d. Describe how injury occurred SUBJECT DRUKE OF JEEP STRUCK GORDRAIL T OVERTURNED 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: -2007 8:36 P Attending 1 Natural 5 Pending investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) HACLES OF EXPENSIVE determined 4 Homicide ō EARYOLK RO PARKTON within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge at the cocurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30/07 1295938819 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0+1 MD 21201 S. GREENE 31. Date filed (Month, Pay Year)

DHMH 17 Rev 1/2001

State Registrar

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Blacker

07-05828 Charles H. Culley

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	or maryiana	•	ificate of			tai i iygi		j. No.	j . 1	
Physici Medical Exam		Decedent's Name (First, Middle, La CHARLES H. CUL	,						Date of Death Month Uly 30, 20			. Time of Death 0805 hrs
		4a. Facility Name (if not institution, gi			T		own, or Location o		oly 30, 20	4c. County of		
Funeral		5007 Queensberry Avenu 5. Social Security Number 6. 8		e (In yrs. las	t hirthday)	Baltin		er 24Hrs.   8	Date of Birth	(MM/DD/YYYY)	N/A	Jaco (State or
Director			X M 2 F	4 7		Months				-1958	Foreign	try) MARYLAND
any	tener to Fig. 1920	10a. State 10b. County		10c. City, T	own or Locat	ion	· · · · · · · · · · · · · · · · · · ·				1	0d. Inside City Limits
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death or item	une	1 X Never Married 2 Marrie	Armed Forces?	X No			Cuban, Mexican,			White,		
	by F		d If Yes, Give Year or Dates:	_			X No specify:			Specify:		
2 hour	eted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5				Occupation (Give king life, DO NOT i			16b. Kind of Bus	iness/Ind	ustry .
5-0036 fled within 77 Hygiene. I other than	ompleted	-11-	-0-		CLI	ERK				EDUCA	rion	
ID 21215-0036 should be filed within 72 hou and Meintal Hygiene 7 is mayked other than "nat natic event, the Medical Exa	ပ	17. Father's Name (First, Middle, Las CHARLES H. CUL.	•						st, Middle, Mi RA CHR	aiden Surname)		
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MD d 2 sho lith and m 27 is aumati		BARBARA MALLOR	Y(MOTHER)	11	3915	5 EDM	ONDSON A					
ore, tra		20a. Method of Disposition  1 XBurial 2 remation 3	Removal from Sta	ite cre	ematory or oth	ner place)	e of cemetery,		ate	20c. Location - (	•	
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Physician		27a Part I. Enter the disease, or comfailure. List only one cause on e		the death. D	o not enter th	ne mode o	f dying, such as ca	ardiac or res	piratory arres	st, shock, or hear		7 I.AND 21217 Approximate Interval Between Onset and
/Medical raminer			Alcohol co		and nar	cotic	intoxicati	on				Death
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F 4	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):							$\rightarrow$	
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760, icate be ex physician the burial	Medical	X UNPENDED  IF FEMALE:	AMENDED #23a, 27, 2	8a-f, p	erME,G8	72, 10	/1/07 TT		_	23d. Date of c	dolivon	
x 687( h certifica tending ph use as the	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fel	tal death	3 Ectopic	pregnancy		Month	Day	/ Year
Box 68's death certificate attending	ysician/	1 Yes 2 No 9 Unknow	Pregnant at 9 Unknown	time of death	h 5 Oth	ner (Spec	ify)					
ch by the	y Phy	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying	cause given in Par	rt I.	23e. Did tob	acco use contrib	ute to the	e cause of death?
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of Vital Records, ng Physician: The law require this certificate has been signered director, page 2 should b	Completed					-			24a. Was ar autops perform	y pr		osy findings available apletion of cause of
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/ital	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 E	R/Outpatient		6.Place of Death (	Check only  Nursing Ho		tesidence 6	Other: S	cene
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sion ttendi death. ctor: /	atio	1 Natural 5 Pending 2 Accident Investigat	ion FNd 7/30/2	2007	Fnd 7:50		1 Yes 2 X	-	ınk			
Division ospital or Attendi hours after death.	Certification:	3 Suicide 6 X Could not determine	be			et, factory,	office building, etc		or Town, Sta	ate)		Route Number, City
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To the within 2 To the complet	Medical	one) 2 Medical Examine										ause(s)
	ž	29b. Signature and title of certifier	10				License number	OME		29d. Date signed		, Day, Year)
9		Theodor M.	renay JA	yan	2		O.C.M.E.			July 31, 200 		
1 cuperu		<ol> <li>Name and address of person who Theodore M. King, Jr., M.</li> </ol>			•	111 Per	nn Street, Balt	timore, N	1D 21201			
St		31. Date filed (Month, Day, Year) AUG 0 7 2	32. egistrar	s Signature	- 19 -	0.0						,
Regist	rar	AUG U / Z	007 Files	1 15	One	123						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Year 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Days 1 ☐ M 2 🛣 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 💢 es 2 🗆 No Funeral Director nor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Black, White, etc. 1 ☐ Yes 2/2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2Å No Specify: þ 3 Widowed 4 Divorced Slac Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should nent of Health and Men ဥ 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip/Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Memorial 4☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

OSEPH L. RUSS

12.2.2. W. North 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Savamous Cell Carcinoma of **Physician** monthe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) WOSPICE 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this . Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. 24 hours after death e Funeral Director:

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To 6 Could not be determined 3 Suicide 4 ☐ Homicide 29a. Certifier Medical (Check only one) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D58303 29d, Date signed (Month, Dav. Year)

31. Date filed (Month, Day, Registrar

6701 CHARCES 32. Registrar's Signature Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St Porson MO

within 2

			1 - For State Registrar	State of Marylar		artment o			nd M		iene.	007	25180
	Dhusisi	49	1. Decedent's Name (First, Middle, Last)							2. Date of Dear Month	h Day	Year	3. Time of Death
	Physici /Medio		Ronald B. Do	orff Sr.						Augus	t 2	2007	10:15 AM
	Examir		4a. Facility Name (If not institution, give str			4b. City, To			Death			unty of Death	
			Manor Care - W		In a desirable of a col	W I If Under 1	reat	On If Under 2	A Hire	0. Data of Bigh		ntgom	
į.	Funeral Director			7. Age (In yrs. 62	Yrs.			Hours	Min.	8. Date of Birth Month, Day Jan . 1	2 <sup>Year</sup> 9	45 Ma	nplace (State or Foreign ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation		<del></del>					10d. Inside City Limits
	Manyl f sho	0	MD Montgom	ery	Silver	Spri	ing						1 ☐ Yes 2Z☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Iteme 23a or 28a-f show ship injury or other traumatic avent, The Medical Exacting roual be notified at another.	by Funeral Director	10e. Street and Number 3429 South Leis	uro World	Dl 177	10f. Zip Co	ode 2090	16		1	0g. Citizer	of What Cou	untry?
	• 23a	ral							. 0 (0	-4 W N			
	item item	-une	11. Marital Status 12  1 Never Married 2 Married	<ol> <li>Was Decedent Ever in L Armed Forces?</li> <li>1 Xes 2 No</li> </ol>	J.S. 13. V	ras Decedent f Yes, specify	Cuban,	Mexican,	Puerto F	city Yes or No- Rican, etc.)		Race - Amer Black, White	
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No .	Specify:			Sp	ecify: W	hite
21215-0036	2 ho	Completed	15. Decedent's Educa	ation	16a. Deced	lent's Usual C	Occupation	on	at wadin		16b. Kind	of Business/I	ndustry
21	thin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Owne	DO NOT use	retired)	nig most	OI WOIKIII	9	Tan	itoria	- 1
2	led w lygier her th	S	12th		OWITE			0.14.45	. N	(E)			
and	be fi	Be	17. Father's Name (First, Middle, Last)  Arlo Dorff							(First, Middle, I		mame)	
Ž	hould d Mei mark matic	2	19a. Informant's Name/Relationship (Type	a Print)	19h Mailin	Address (S				Route Number		own State 7	in Code)
Maryland	ith an 27 is r		Holly Kline /da										aware 1997
	r Hea Hem Item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of					ion - City or 1	
Ē	Page: ent o nt: #f		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cometery, cren ardens	of F	ait	:h   {	8/6/	07	Ross	sville	e MD
Baltimore,	partm porta y inju		21. Signature of Funer & Service Licer see		1 / 22	. Name and	Address	of Facility	300	MACE	Ave	. Bal	to. MD
<b>m</b>	Depa impo eny i		1 Blue 1e	Les Connel					eral	Home	of I	Essex	21221
ţ.			23a. Part1 Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	f. Bo not ent	er the mode o	of dying,	such as c	ardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	carcinom	a meta	stati	c t	.o a	roir	1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse									
\$		J.	Sequentially list conditions, if any, leading to immediate	non smal	l cell	carc	ino	ma c	of l	ung			
	nsit	Examiner	Cause (Disease or injury	240 (0 (0) 40 4 00 100	440.100 01).								
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9	ng ph	Med	IF FEMALE:						.,				
Вох	ith ce itendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	<li>c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet</li>		Ectopic preg	nancy				23d	. Date of delin	very Day Year
о П	es that the death certific igned by the attending p be detached for use as	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of one of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of	death 5□	Other (speci	ify)					WORK	Day Foat
P. 0.	hat the	Ph	Part II. Dther significant conditions conti	ibuting to death but not re-	sulting in the u	oderlying caus	sa givan	in Part f		23e. Did tol	nacco usa	contribute to	the cause of death?
Records,	Attending Physician: The law requires that the rideath. sctor: After this certificate has been signed by the the funeral director, page 2 should be detached.		renal cell		,	, a a a a a a a a a a a a a a a a a a a	oo g. oo				s 2 🗆 N		bably 4 Unknown
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æ	ysician: The lavins certificate has director, page 2	ш	CODACCO SMO	rei						autops	y ned?	prior to c death?	ompletion of cause of
ta	an: T	0	25. Was case referred to medical				2	6 Place	of Death	(Check only on		1 L Yes	2 🕱 No
<u> </u>	ysicii is cer direct	To B	examiner? / 1 ☐ Yes 2 🐴 No	spital:	] ER/Outpatien	t 3 DOA	0.1			e 5 ☐ Reside		Other (Spec	eify)
0	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury		Injury a		1	8d. Describe ho			
Sio	endir Bath. or: Al	Satic	2 Accident investigation			М		s 2 🗆 N	lo				
Division of Vital	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, o	office		2	8f. Location (St City or Town		umber or Ru	ral Route Number,
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Tacertifying Physic	oings To the heat of	owladae daad		the to -	dat- '	l mis =:			4	
	24 ho 24 ho Fun etely 1	edical	(Check only one)	cian: To the best of my kn  or: On the basis of examinated manner stated.	ation and/or in	estigation, in	my opin	oate and ion, deatr	place, a n occurre	d at the time, d	ause(s) and ate and pla	d manner as ice, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	<i>(</i> 1)		29c. L	icense n	umber		2	9d. Date s	igned (Month	, Day, Year)
	<,		- Rabert H. &	lucial M	D		D0	0555	522		8/3	3/07	
1	Y		30. Name and address of person who com	apleted cause of death (fte	m 23a) (Type,	Print)							
0			Robert H. Geran	d MD 1500	Fores	t Gle	n R	oad	Sil	ver Sr	rino	MD 2	20910
62	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								
	Registr	ar	- AUG 0 7 200	1 Element 1	U 142								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2007 Month **Physician** Davis 6 7:05a 8 Jacquelyn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richy Hospital NA Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 70601954 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2√□F Md. 214-62-9099 53 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1X Yes 2 □ No Baltimore Md. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r items 23a or 2 USA 21213 1759 E. North Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or item Examiner Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner. ☐Yes 2 XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Beautician 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Celestine Scott George ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau 1012 Bethune Rd., Baltimore, Md. Daughter Denise Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-13-07 Baltimore, Md. Greenmount Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Tumor with metastasis Carcinoid 4 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Box 68760,C The law requires that the death certificate be executed burial-trans physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 State (Specify) 1+03 1 C 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Richy Hospice Baltoner MA Itavoid a Stand ford 10 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 7 2007 Registrar

07-05947 James Darby

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Darby	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No.	519
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death  North	
<i>p</i> x	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Johns Hopkins Bayview Medical Center  4c. County of Death  Baltimore	
Funeral Director	5. Social Security Number 218-86-7749 6. Sex 12 Months Days Hours Min. Sept. 19, 1964 Country Alab	
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City	
ryland a-f show f once	MD Baltimore Baltimore 1 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 X No
th the Maryland 23a or 28a-f sho notified at once.		
s after death with ran", or items 23 nainer must be no by Funeral	3 Wildowed 4 Divorced in res, drive real 1 Tes 2 No specify. Specify.	ick,
2 hour "natu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Media	James F. Darby Sharon Faye Black	
and 2 should lealth and Me tem 27 is ma traumatic ev	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  316 Oberle Ave. Balto. MD 21221	
More Pages 1 tent of 14 in other	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, Bright of Crematory Crematory Crematory Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Crematory Removal from State Bayview Removal from State Bayview Crematory Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal from State Bayview Removal	
Baltimo permit. Pag Department Important: injury or od	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. M. Connelly Funeral Home of Essex 2122	
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caustof the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Cirrhosis of liver	nset and
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
red Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
t0, e be executed ysician and burial - transit	events resulting in death) Last Due to (or as a consequence or).  d.	
760, cate be execut physician and he burial - tra	WINDERD AMENDED #23a, 27, perME, g871, 9/7/07 TT  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 6876 e death certificate the attending phy ed for use as the l hysician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  1 Yes 2 No 9 Unknown  9 Unknown	Year
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To the Hospital within 24 hours a To the Funeral 1 Completely filled		
To with the com	29b. Signature and title of certifier  29d. Date signed (Month, Day, Year)  O.C.M.E.  August 4, 2007	1
0.7	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** eorganna August LDODAM 02 07 /Medical 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltum Cit If Under 1 Year 5. Social Security Nurliber 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 81 Director 220-14-2275 9,1925 Maryland Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director Baltimore City Maryland N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or ' edical Examiner must be n 21224 United States Funeral 6321 Hudson Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 28 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by Specify. 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Esskay Meat Co. i. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant; If Item 27 Is marked other th jury or other traumatic event, the Meat Packer 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Fetterhoff George W. Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alberta Bischer (Sister) 705 Compass Road Apt. 236 Middle River, MD 21220 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other ta Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Cem. 8/6/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCVD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown P.0. 5 Other (specify) 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2❷ No 24a. Was an page 2 autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28684 4940 Eastern Ave. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21224 new 31. Date filed (Month, Day, Year)
AUG 0 7 2007 State

Registrar

Physician /Medical Examiner

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 28a-f show ns 23a or 28a-f sh must be notified , or items 23a 'natural', than "

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed the burial-tra physician as ed by the a detached f signed to funeral director, page 2 should I certificate has Hospital or Attending Physician: After this hours after death uneral Director:

Division or Vital Records, P.O. Box 68760,

For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 2, Donna Lee DeVitis 5:47 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) Nov 25, 1957 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 □ ¥ Months Days Hours Min. 192 48 5343 49 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 United States 2170 Kahill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Cachation Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary School District 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Deddis Matilda Almasy ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel DeVitis (Husband) 2170 Kahill Drive, Waldorf, MD 20601 Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug 6, 2007 1 Burial 2 □ Cremation 3 □ Removal from State Queen of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc 6633 Alexandria FerryRoad, Clinton, MD 20735 23a. Parl . Enter the disease, or complications that caused the shock, or heart failure. List only one cause ach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy autops, performed? Yes 2⊠No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending 2 Accident investigation 1 Tyes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a textertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0046374 30. Name and address of person on who completed eause of death (Item 23a), (Type, Print) 20032 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 200<sup>Year</sup> **Physician** 0<sup>Day</sup> Michael J. Duncan, Sr. August 10:22 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8325 Dalesford Road Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 218-46-2652 60 Director Maryland 20, 1946 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "..." 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Md. Baltimore Towson 1 ☐ Yes 2 ☑ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8325 Dalesford Road 21234 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 ✓ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. <u>Ş</u> Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Computer Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Duncan Cecelia Walter P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jayson Duncan/ Son 8325 Dalesford Rd. Towson, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 8-7-07 Towson, Md. 21. Signature of Funeral Service Lighns 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md.

23a. Part I. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke 4 one da /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) sion or Vital Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by abuse 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No The law autopsy performe te 25 No or Attending Physician: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home Scanne 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier DO052583 (ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

David J. Nailman, No

AUG 0

Year)

2007

31. Date filed (Month, Day,

5600 Lock

32. Pojistrar's Signature

Raven

Block.

Bultomore M& 21239

		For 1_ State	State of Ma	arylan		artment of F			1ental H	ygiene	)		
2.0		Registrar  1. Decedent's Name (First, Middle, Las	st)		Cei	tilicate of t	Dean	n	2. Date of I	Reg. No		3. Time of D	O
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	. 2	FREDERICK MEMOR 5. Social Security Number 6. S			last hirthday	FREDER		er 24 Hrs.	0 Data 6 F	2:-41-	FREDER.		-
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and		Usual Residence of Decedent  10a. State 10b. County		10c. City	/, Town or Lo	cation						10d. Inside City	Limits
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arylano should be t and Mental s marked o umatic eve	70 [	THOMAS J. DEMI	PSEY, SR.	•				CATHE	ERINE	CA	SSERLY		
Aar 2 sho 1s m 1s m		19a. Informant's Name/Relationship (				ng Address (Street						' '	
		CATHLEEN SIPOCA  20a. Method of Disposition	Z/ DAUGH			OAKRID	GE I		NEW N				
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Baltimo permit. Pag Department Important: It any Injury o		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Secretarians)		BA		CREMATO						,MARYLA	.ND
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/Medical		resulting in death)	a. Due to (or as	a consequ	uence of):	occident							
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UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. On the Funeral Director: After this certific, completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on the basis of and manner sta	examinat	wledge, death ion and/or in	occurred at the ting vestigation, in my o	ne, date pinion, d	and place, eath occur	and due to the red at the tim	ne cause(s e, date an	) and manner a d place, and du	s stated. e to the cause(s)	
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rthur David Davie		e of Maryland /	Depart	tment of	Health and				<b>DIC.</b>	107 0510
	Registrar	OOt\	Certi	ficate of i	Death		2 Date	Reg. e of Death	No.	3. Time of Death
Physician/ Medical Examine	er	ARTHUR	DAVI				Mor Aug	ith E		1915 hrs
	4a. Facility Name (if not institution, g Harbor Hospital Center	give street and number)		45	. City, Town, or Baltimore	Location of	Death		4c. County of	Death
Funeral	5. Social Security Number 6.	Sex 7. Age	(In yrs. last	t birthday)	If Under 1 Year	If Under	24Hrs. 8. Da	ate of Birth		9. Birthplace (State or
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re, MI s. I and 2.5 of Health 8 of freen 27	20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from Sta		ace of Disposit ematory or othe	ion (Name of cer er place)	metery,	Date		20c. Location - C	City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Other Spec	ify:	Вау							more, MD
Baltimore permit. Pages I a Department of He Important: If ite	21. Signature of Funeral Service Lic	ensee							Funera na, MD	al Home, PA 21122
Physician	23a. Part I. Enter the disease, or co		the death. D							t Approximate Interval
/Medical xaminer	failure. List only one cause on Immediate Cause (Final disease	each line. a. Cardiomo alv	and hi	ventricu	ılar hyper	trouhy				Between Onset and Death
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876 tificate ng phy as the t	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of pregna	ancy	al death 3	Ectopic	pregnancy		23d. Date of d Month	elivery Day Year
). Box 68760, the death certificate be by the attending physic ched for use as the burnerician/Med	past 12 months?	4 Pregnant at	time of deat	h =	er (Specify)					
that the de ned by the detached f	Part II. Other significant condition	9 Olikilowii	but not res	ulting in the ur	nderlying cause o	given in Par	t I. 2	3e. Did tob	acco use contrib	ute to the cause of death?
ires that the signed by libe detach								1 Yes	2 No 3	Probably 4 🗸 Unknown
Division of Vital Records, I tal or Attending Physician: The law requires its after death.  *I Director: After this certificate has been signed in by the funeral director, page 2 should be perfification: To Be Completed.	9						2	4a. Was ar autops	y pri	ere autopsy findings available for to completion of cause of
RecC The lav							1	✓ Yes 2		eath? ✓ Yes 2 No
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Division o ospital or Attending obstitute or Attending the death.  Uneral Director: After the by filled in by the fune I Centification:	4 Homicide determine	ned (Specify)								
		sician: To the best of mer:On the basis of exam	y knowledge mination and	e, death occurr d/or investigati	ed at the time, da on, in my opinior	ate and plac n, death occ	ce, and due to curred at the ti	the cause me, date a	(s) and manner a nd place, and du	es stated. e to the cause(s)
To the Ho within 24 To the Fu Completel	29b. Signature and title of certifier	and manner stated.	<del>-</del>		29c. Licens	e number				d (Month, Day, Year)
1 A	1/	11.71	7	1	O.C.	M.E.	CME		August 2, 20	007
152	30. Name and address of person w								1	
2 CV	Theodore M. King, Jr., M	er/a 1			111 Penn St	reet, Bal	umore, ME	21201	<del></del>	
Stat Registra		2007 32. Registra	s Signatur	Y dos	di)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 **Physician** Charles Dundorf /Medical County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number Age (In yrs. last birthday, **Funeral** Months Days Hours 1 M 2 □ F 7/19/1946 198-38-1368 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show that if item 27 Is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 ☑ No Director MD Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 USA 580 West Court by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 2 Yes, Give 2 🔀 No 1 Never Married 2 Married 1∐Yes 21√2 No Baltimore, Maryland 21215-0036 Specify. white 3 Widowed 4 Divorced ear or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Loyd Dundorf Jane Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Mrs. Donna Hustand/friend Glen Burnie Md 21061 508 Joy Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/5/2007 Stephensville, MD Chesapeake Cremation 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature Stameral M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician disease or condition resulting in death) /Medical sequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 88760 Physician/Medical worker 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23rt Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 robably 1 🗌 Yes 2 🗌 No 4 □Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1□ Yes 2 N No 1 🗆 Yes Division or Vital l or Attending Physician; completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ☐ ER/Outpatient 3 ☐ DOA npatient 1 TYes Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital TCcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 0 30. Name and address of person who ed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ISON /Medical City, Town, or Location of Death Name (If not institution, give street and number, Examiner and all Stown Baltimore Year If Under 24 Hrs Age (In yrs. last birthday, Birth Day 9. Birthplace (State or Foreign **Funeral** Months Min. Yrs Director MOIS permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2☑No 1 ☐ Yes Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DONOT use retired) +NOIOAY 14851.Stant College (1-4or 5+) Elementary/Secondary (0-12) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid Be ပ္ Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, dity or Town, State, Zip Code) Sister Homewood 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State ∄ ☐ Other (Specify) 21. Signature of BUS BaltoMD 21229 23a. Part Ente t shock, or kee the ease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C ...v e (Final disease or condition resulting in death) **Physician** robabl /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mg Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Medical Certification: To Be Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of page 2 performed death? 1 ∐ Yes After this certificate 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 Inpatient 27. Magner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica filled in by the funeral Sompletely

29a. Certifier

29b. Signature and title of

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST MILTON 2007 ELY 1:00P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/30/1923 5. Social Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours ovintry MD 218-16-1639 83 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? 2905 FALLSTAFF ROAD, APT. #43 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No WHITE Specify. Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY LAW Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT LAWYER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAHAM ELY MOLLIE ANNA GLAZER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID BERMAN / COUSIN 6508 GARDENWICK ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of Marketon, Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Juneral Septice License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Moafins NOMUSUA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate educe. Enter the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Milton, F Ö

attending physician requires that the death certificate be the signed by certificate has been Physician: After this or Attending nin 24 hours after death the Funeral Director: Hospital

**Physician** 

/Medical

Examiner

**Funeral Director** 

Be Completed by

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Physician/Medical Examiner

Completed by

Be

Certification: To

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 22. -- any injury or other traumatic event, the Market

**Physician** 

/Medical

Examiner

for use as

page 2 should be

funeral director.

filled in by

completely within To the

DHMH 17 Rev 1/2001

Registrar

29c. License numbe

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Towson town Blud/Bolto

31. Date filed (Month, Day, 32. Agistrar's Signature

29b. Signature and title of certifier

Eghosa 1	Miaes
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JNK UNK		State of Maryland / 1- For State Registrar	Departmer Certificat			Mental H	-	teg. No.	20	17 2519
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  EGHASA E. EHIGIAMUSOE			0: 7		2. Date of Dea Month August 1	Day 2007	Year	3. Time of Death 0222 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital			b. City, Town, or L Baltimore Cit	у			N/A	
Funeral Director		255-87-7669 1XM 2F	(In yrs. last birthd	ay) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	8. Date of Bi	•	Forei	rthplace (State or gn <sup>puntry)</sup> GEORGIA
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ith the Maryland 23a or 28a-f show notified at once.	Director	MD N/A  10e. Street and Number  2114 E. LOMBARD ST.	BALTI	.MOR	10f. Zip Code 21231				n of What Cou	77
r death w	Funeral		Ever in U.S. 1	If Ye	Decedent of Hisp s, specify Cuban,	Mexican, Puerto			White, etc.	rican Indian, Black,
71215-0036 ldbe filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade com  Elementary/Secondary (0-12) College (1-4 or 5	du	cedent	Yes 2 X No s Usual Occupation st of working life. I	n (Give kind of		16b. Kin	d of Business	CK /Industry
다 a 뜻 a 됨	Completed	17. Father's Name (First, Middle, Last)		ST	UDENT 18	3. Mother's Name		Maiden Su	EDUCAT	ION
MD 2121 d 2 should; be fi lth and Mental I n 27 is marked numatic event,	To Be	LUCKY EHIGIAMUSOE  19a. Informant's Name/Relationship (Type, Print) PATRICIA MINES (MOTHER)			Address (Street	and Number or		mber, City		e, Zip Code) AND 21231
r e e a	1	20a. Method of Disposition  1 X Burist 2 Cremation 3 Removal from Star	20b. Place of E	Disposit	ion (Name of cem	etery,	Date 7-2007	20c. Lo	cation - City o	
Baltimore permit. Pages I Department of I Important: If i		21. Sign ture of Funeral Service treensee TATHAN	D. HIBN					FUNER	AL HOM	
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	miner	Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause	. ,		_			5		
50, te be executed ysician and burial - transit	Exa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consert d.	quence of):							
Box 68760, death certificate be exchanged the attending physician of for use as the burial.	sician/Medical	UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom	e of pregnancy	Feta	al death 3	Ectopic pregn	ancy		Date of deliver	ry Day Year
). Box 6876 the death certificate by the attending phyched for use as the l	Physici	1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death	5		er (Specify)	en in Part l	23e. Did t	obacco us	e contribute to	the cause of death?
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tal Recor	Completed	~					1 <b>✓</b> Yes	ormed?		completion of cause of
of VI: ng Physi nfer this neral dir	n: To Be	27. Manner of Death 28a. Date of Injur (Month. Day Ye	ar)	ne of In	3 DOA C	at Work?	ng Home 5  28d. Describe Subject sho			er:
Division pital or Attendir ours after death.	Certification:	2 Accident Investigation . 28e. Place of Inju	hrs ury - At home, farm			es 2 No		Street and	Number or R	ural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner:On the basis of exam	knowledge, death				due to the cau	se(s) and i	manner as sta	ted.
To viri	Me	and manner stated.  29b. Signature and title of certifier  AUI AUI AUI AUI AUI AUI AUI AUI AUI AUI			29c. License O.C.M				te signed (Mo	onth, Day, Year)
37		30. Name and address of person who completed cause of de Carol Allan, MD Assistant Medical Exam	iner 111 Pe	enn S	treet, Baltimo	re, MD 2120	1			
Regist		31. Date filed (Month, Day, Year) 32. Repstrar' AUG 0 7 2007	is de	1	de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della					
DHMH 17 Rev 1/20	01		ORIG	MAL						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #8, perFH,0870, 8/27/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month you IRMA FRIEDENBERG 03:00 Ayut 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Singi Hospital Lhmore Baltimore 18. Unite of Birth 02/13/<del>1923</del> 1924 Birthplace (State or Foreign Country) 1 M 2 1 F Min. Months 218-14-0820 84 **GERMANY** Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8204 TAMA COURT 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. WHITE Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REALTOR REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FELIX KLEEMAN EVA GREENBAUM 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8204 TAMA COURT - BALTIMORE, MD 21208 LESTER FRIEDENBERG/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State HAR SINAI CONG. 08/06/2007 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes ♀ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate has page 2 Physician: The funeral director, this Hospital or Attending 24 hours after death. Funeral Director: A completely filled in by within 2. To the I

Physician

Examiner

**Funeral** 

Director

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ; any injury or other traumatic event, the Medical Examiner mu

**Physician** /Medical

**Examiner** 

filed within 72 hours after

Pages 1 and 2 should be

Baltimore,

5-0036

Funeral Director

Be Completed by

2

Physician/Medical Examiner

Be Completed by

Certification; To

(Check only one)

29b. Signature and title of certifier

Month, Day, Year)

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riedenberg

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/Medical

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1, perMD, G870, 8/16/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Elnora Gibson 2. Date of Death Month 3. Time of Death Day Year **Physician** 5.47 AM Aug 2007 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Health Care Sulfinone
If Under 1 Year If Under 24 Hrs. Social Security Number 7, Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 Yrs. marylano Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 des 2 No Baltimore NIA Director MD 10e. Street and Number 10g. Citizen of What Country? USA Morle Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AID Hospital 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Johnson 19a. Informant's Name(Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milded Livington Baltimore Hummon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Paneral Service Le 22. Name and Address of Facility Fary P. March 17H 240 Fredhillon Pass Balto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician DIAGE TES newins disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HIPERTENSIN Sequentially list conditions, if any, leading to infiliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examin signed by the attending physician and the detached for use as the burial-transit STARIE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical CORONANT DI SEME IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Lipi DEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown the Hospital or Attending Physician: The law requipin 24 hours after death.

The funcar Birector: After this certificate has been mpletely filled in by the funeral director; page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No L<sub>o</sub> 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTENDONG · 4005 DO516948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21217 300 Arnons PUTET 3+1 BALTIMORE fuite 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 7 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛴 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 6:30 PM 2007 /Medical Charles Griffin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Batt move. Cty.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Since Hospital of Baltimore Charles Grith 5. Social Security Number **Funeral** Director 49 217-68-1282 08/02/1958 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at 1 Yes 2 No Director MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a Funeral the Medical Examiner must USA 14. Race - American Indian, 3301 West Garrison Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 "natural", or Specify. by Specify. 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 1 and 2 should be filed withi Health and Mental Hygiene. attent 12 Carpenter. is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Keeley Alicia Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra 6613 Touchstone Ct. Baltimore, MD 21214 Davida Hopkins/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 08.09.07 Beltsville, 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 Donation 5 Dother (Specify)/ Chesapeake Crematory Inc.
22. Name and Address of Facility Beltsville, Maryland 21. Sigrature of Funeral Service Licenses MOILY Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Manuland 21286
Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** Due to (ol as a consequence of) 1 day disease or condition resulting in death) /Medical Examiner Brain death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Meningitis

Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-tran P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HIV/AIDS. Cadvanud 2 No 3 Probably 4 Unknown Crubincollal meningition been: 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: After the Funeral Director of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 08/03/07 Crange 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore. Kapil Gangwal MBBS 31. Date filed (Month, Day, Year)
AUG 0 7 2007 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed ettending physicien a for use as the burial Division of Vital Records. P.O. Box 68760. signed b been s funeral director Director: A within 24 ho

To the Function

**Physician** 

/Medical

Examiner

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Certification:

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Director

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2 should be filed within 72 hours after and Mental Hygiene.

permit. Pages 1 and 2 should be fitte Depertment of Health and Mental Hyy Important: if Item 27 is marked othe any injury or other traumatic event, once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State	of Maryland / Depart <i>Certi</i> i	ment of ficate of		d Mental Hy	_	g. No.	007 2520
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*	University of Maryland Me	· ·		Baltimore			Harford	
Funeral	Social Security Number     6. Security Number	, ,	birthday)	If Under 1 Year		8. Date of Birt		9. Birthplace (State or oreign
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5-0036 Iled within 7 Hygiene I other than the Medica	12 17. Father's Name (First, Middle, Last)		Bar B		18.Mother's Name	(First Middle A	Restur	ant
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Ne Me	19a. Informant's Name/Relationship (Toni Myers (Mothe						nber, City or Town,	
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite njinry or other tr	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify.		matory or oth view C	rematory	8-0	2-2007	Baltimor	e, Maryland
3alti ermit. Departr mport njury	21. Signature of Funeral Service Licer	see		ame and Address	Sch	imunek	Funeral l	Home of Bel Air
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/Medical	failure. List only one cause on ea			, ,			n.	Between Onset and Death
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Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the the Medical Certification: To Be Completed by Physician/Mi	(Check only one) 2 ✓ Medical Examine	<ul><li>an: To the best of my knowledge,</li><li>On the basis of examination and and manner stated.</li></ul>					and place, and due	e to the cause(s)
	29b. Signature and title of certifier	Dan.		29c. Licens				(Month, Day, Year)
	rate Uron	-TOller	10	O.C.	IVI.⊏.		August 1, 20	IU /
v	30. Name and address of person who Patricia Aronica-Pollak MI	). Assistant Medical Ex	aminer	111 Penn St	treet, Baltimor	e, MD 2120	1	
State Registrar	31. Date filed (Month, Day, Year)	32. Rogištrar's Signature	Los	de)				
DHMH 17 Rev 1/2001	MICE OF E	de.	ORIGINA	 L				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** DORIS AGNES GRECO 4:40AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITA OLUM HOWARD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 🕅 F 80 Director 578.30.5134 March 1, 1927 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ?7 is marked other than "naturat", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7003 Lovell Drive 20782 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mential Hyglene. Important: If item 27 is marked other than "natural" or item any injury or other trainmetts. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Bauman Anna O'Connor ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. William R. Greco/Husband 7003 Lovell Drive, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition August 8, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombment Gate Of Heaven Cem. Silver Spring, MD 2007 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 21. Signature of Funeral Service Licensee 23a. Part1. Enter the relation asset or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leaf it fail in e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septic sh dai disease or condition resulting in death) /Medical Due to (or w a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ ₩6 24a. Was an autopsy performed acute rena 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD, D36845 FCCP

Registrar
DHMH 17 Rev 1/2001

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State

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31. Date filed (Month, Day, Year)

AUG 0

7 2007

MD 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) War-Clin ug cuyley

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Ε. 2007 Patricia Heck 3:15 p /Medical August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3512 Mill Green Road Street Harford 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 1 1951 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🛛 F 56 169-40-2432 Director Maryland Usual Residence of Decedent p.rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3512 Mill Green Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Greer ၉ Mary Jane Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Heck - husband 3512 Mill Green Road, Street, MD<u> 21154</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/7/2007 Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. 22. Name and Address of Facility
Cremation Society of Maryland,
299 Frederick Road, Baltimore; MDc · 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBRO VASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 ments?
1 ☐ Yes 2 ☑ No 23d. Date of delivery ed by the atten detached for u 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed.

1 Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manyler of Death 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 □ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 50040 08-07-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BY # 102; EDGENOOD, MD 21040 ENTER State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 1, 23a e per doc 8870 8-15-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death OFOR 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Joyce Patricia Gile Hundley 04<sup>Day</sup> 08 Month Joyce Patricia 2007 8:40 a<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center For Hospice If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month Day Year 1/6/1932 9. Birthplace (State or Foreign Days 1 □ M 2 DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 816 Stevenson Ln. 21286 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. White 1 Yes 2 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemist FederalGovernment 17 Father's Name (First Middle Last)
Rexford R. Gile 18. Mother's Name (First, Middle, Maiden Surname) Marium Bowles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hundley/husband Stevenson Ln. Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 8-6-2007 Beltsville, MD 22. Name and Address of Facility 8717 Green Pastures Dr.21286 21. Signature of Funeral Service Licensee mo1358 Cremation&Fun. Alternatives Towson.MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final UNGCAN 8 mouths disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No 9☐Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops, performed: 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Physician /Medical Examiner The law requires that the death certificate be executed Ö ئے R/4/07 Division or Vital To the Hospital or Attenct within 24 hours after death To the Funeral Director:

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

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Physician/Medical

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Completed

Be

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

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After this certificate

filled in by the funeral director,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 5, Day 2007 **Physician** LeRoy Glenn Hanks, Sr. 3:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center For Hospice Towson If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/24/1931 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days XXM 2 F Maryland 213-28-2564 75 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 53a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits be notified at 1 ☐ Yes 27XNo Director Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 317 Magnolia Terrace U.S.A. must Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. MXYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes XX No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Car Manufacturer Production Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic ever Ira Hanks Hilda Wittstadt ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Hanks (Wife) 317 Magnolia Terrace, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/08/2007 Oak Lawn Cemetery Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home, P.A. Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 40ars 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autop performe 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA Manner of Death
Natural
Accident 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 3 🔲 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 4:55 P M Wilma Heller /Medical Julv 30, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Arm

It Under 1 Year | It Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nonths | Days | Hours | Min. | Sept. 25,1925 Glen Meadows Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 81 Director 213-20-2504 Maryland Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Exa. iner must be notified at Director 1 Yes 2 XNo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 2704 Gingerview Lane U.S.A. 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iten any injury or other traumatic event, Ite Marial Exerti 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: by Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Κ. Benjamin Heller 2 С. Margaret Siegle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Heller Nephew 2704 Gingerview Lane Annapolis, Maryland 21401 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Baîtimore Hebrew 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify)
Signation Full ral Service Licensee Conregation Cemetery 8-2-2007 Baltimore Maryland 21. Signati 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ULMONARY **Physician** HRONIC UBSTA /Medical to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and -tran Due to (or as a consequence of): physician at s the burial-t P.O. Box 68760. Physiclan/Medical attending pt tF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy performed? Yes 200 No 1 Yes Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No Hospital: Other: Surring Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No hours after deatl unerel Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á determined 4 Homicide illed in To the Hospital of within 24 hours at To the Funerel D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51228 12007 MOPAC 1 BACIMOR OLLING GROSS ROADS #15 AMANA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 Registrar

07-05749 Mary Hines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State		Certifica	ite of	Death			leg. No.		3. Time of Death
Physician/		MARY HINES  2. Date of Death Month Day Year July 26, 2007  3. Time of De. Month Day Year July 26, 2007  4. County of Death									
Examine	-	MARY HIN	. —					July 26, 2	2007	of Death	
	48	. Facility Name (if not institution, g	ive street and number	)	4	b. City, Town, or I	_ocation of D	eath	4c. Cou	inty of Death	
	н	Johns Hopkins Hospital				Baltimore				N/A	
Funeral	5.	Social Security Number 6.5	Sex 7. Ag	ge (In yrs. last birth	nday)	If Under 1 Year			irth(MM/DD/Y	YYY) 9. Birti	hplace (State or
Director			N 05-15	4.0	Yrs.	Months Days	Hours	Min. DEC.	6.195	Col	NORTH Intry) ROLINA
Director			M 2X F	49	113.		100	IDEC	6,195	/CA	ROLLNA
	_	Sual Residence of Decedent  Da. State 10b. County		10c. City, Town	or Locati	on					10d. Inside City Limits
v any											1 Yes 2 No
sho,	5	MD N/A		BAL	LTWC				10g. Citizen o	of What Cour	Λ
Maryland 28a-f show d at once.	1	De. Street and Number				10f. Zip Code		-	rog. Citizen c	JI VYTIAL COUI	id y:
ith the Maryland 23a or 28a-f sho notified at once	5	1502 N. DURHA	M ST.			2121	3	*.	USA		
ith th		1. Marital Status	12. Was Deceder	t Ever in U.S.	13. Wa	s Decedent of His	panic Origin?	? (Specify Yes or N		Race - Ameri White, etc.	ican Indian, Black,
r death with or items 23	₽	XNever Married 2 Marrie	ed Armed Forces		l If Y	es, specify Cubar	, Mexican, Pi	uerto Rican, etc.)		vvinte, etc.	II'm
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Me lica	8	WARREN PAIGE					EDN.	A HINES er or Rural Route N	on City o	- Tourn State	7in Code)
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Baltimo permit Pages Department o Important: injury or oth	L	4 Ponation 5 Other Spec				CEMETE Name and Addres	CE - Miles				
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P.O. Box 68760, es that the death certificate be executed signed by the attending physician and be detached for use as the burial i transit	瑞		d								
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x 6 h cer tendi	<u>:</u>	<u> </u>	4 Pregnant	t at time of death	5 (	Other (Specify)					
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of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certificate has been signed by the attending uneral director, page 2 should be detached for use as the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr		25. Was case referred to medical	115 96				100	(Check only one)			
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Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	a	29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge,	death oc	curred at the time	, date and pla ion, death oc	ace, and due to the curred at the time.	date and place	e, and due to	the cause(s)
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044		30. Name and address of person	who completed cause	of death (Item 23	a)						
10		30. Name and address of person Susan Hogan MD.	Assistant Medica	l Examiner	111 P	enn Street, B	altimore, I	MD 21201			
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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

nours after death.

neral Director: After this

filled in by the funeral di Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number DEA # 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435B18127 Aua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Baltimore, MD 21201 Laura Babkes

State Registrar

32. Pregistrar's Signature 31. Date filed (Month, Day, Year) AUG 07 2007

2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician Ferdinand F. Jaworski 12:44 P  $^{M}$ 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle River Baltimore Ivv Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F 212-12-5932 90 Yrs. Director 9-13-16 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore r 28a-f sh notified Kingsville 1 ☐Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 8128 Bradshaw Rd. 21087 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates:WW∐ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marked other than 8 yrs Workshop Clocks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Lepartment of Health and Mental I In portant: If item 27 Is marked of John Jaworski Aniela Schreck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Bernice Kuehne-sister 11215 Arbutus Ave. Bradshaw, Md. 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stephens 8-6-2007 Bradshaw, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home, Inc. 4 Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emen Dai /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease on injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): physician are the burial-t Box 68760, Physician/Medical as attending IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? for Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2. No 3 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed page certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death. uneral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) me JULA LOL 1124 Mace Ave, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 Registra 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 5, 2007 **Physician** 9:05 Henrietta James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) Oct 26, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F North Carolina 577-26-2634 92 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 XNo Director Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 1906 Lindemann Lane U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify: 3altimore, Maryland 21215-0036 <u>Ş</u> 3 ☐ Widowed 4 🏿 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Accounting Waverly Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ada James Henry Young Sara Grubb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. James-son 1906 Lindemann La., Lutherville, MD 21093 27 permit. Pages 1 ar Department of Heal Important: If Item 27 any injury 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 8/8/07 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licen William G. Dau 1050 York Rd., Towson, Md 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 9☐Unknown Dav 5 ☐ Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing the death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Record 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy Division or Vital R perform certificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) certifie 29d. Date signed (Month, Day, Year) 29b. Signature and title MED

Registrar DHMH 17 Rev 1/2001

State

32. egistrar's Signature

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

8.6.67.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Vear **Physician** 11:15 aM 2007 Ju<sub>1</sub>y 23 Hseo-Chin Jen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1⊠M 2□ F Yrs. 85 June 20, 1922 China Director 579-60-9811 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in then "natural", or Items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 🛭 No College Park Maryland Prince George's Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 5049 Berwyn Road 20740 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene, other then "natural", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Congress Library Reference Librarian 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fit Health and Mental H Item 27 Ie marked ot other treumatic ever Be Yu-Ying Ma ပ Jian-Qing Jen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health at nt: If Item 27 let y or other 5049 Berwyn Road, College Park, Maryland 20740 Teresa Teh-Hwa - Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 7/31/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Multiinfarct Cerebrovascular Accident **Physician** /Medical Due to (or as a consequence of) Examiner Cerebral Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pl 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the to detached 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Tes 2 🔀 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 🖾 No 1 ₺ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 081031 mimmeter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month)

MASSAINGTON ADVENTIST

32 Registrar's Signature

TANOMA PARK, 4D-20912

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

一乙乙山丛

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day GUS KAIFOS 31, July 2007 1:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 263 46 4493 72 11,1935 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 M No Anne Arundel MD Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8046 Woodholme Circle U.S.A. 21122 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1952 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 1956 White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US Dept of Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspector Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George Kaifos Helene Vasilakos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Klara Kaifos/ wife 8046 Woodholme Circle Pasadena, MD21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Bayview Crematory 8/3/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral 169 Riviera Dr. Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Et al. John Scause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ► No 24a. Was an autopsy performed

Physician /Medical Examiner

be executed

Division or Vital Records, P.O. Box 68760,

Physician

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notifiled at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me

death

filed within 72 hours after

3altimore, Maryland 21215-0036

/Medical

Examiner burial-transit attending physician for use as the buria Physician/Medical signed by the a Completed peen has certificate Be ဥ this funeral After Certification: death. after death.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1** No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely filled in by the within 24 hours a 2

Attending

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State Registrar

Medical

29a. Certifier

29b. Signature and the of gert

iled (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed, (Month, Day, Year) 0

Ofen Burnee MD 21061

and manner stated.

Mus

208 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Year aro 2 ILMan 55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** 213-50-3339 Days Hours 1 ☐ M 2 🛛 F 48 **Director** 04/15/1959 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notifled at MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 38 MERINO COURT 21117 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural"; or items 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event. The 5+ VETERINARIAN VETERINARY MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTIN KLEINMAN SONYA MYERBERG ္ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONYA GICHNER / MOTHER 3315 SHIRLEY LANE - CHEVY CHASE, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CHIZUK 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 08/06/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AMUNO CONG. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee Tolet 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Circhesis /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-1 P.O. Box 68760. physician Physician/Medical the th as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by icate has been si, r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☐ YNo 2 1 🔯 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Hospital or Attending After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural within 24 hours after death.

To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 & Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 444 /Medical wilty Name (If not institution, give street and number) Examiner 4b. City, 4c. County of Death If Unde 8. Date of Birth (Month, Day, Year) Social Security Numbe Age (In yrs. last birthday) 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1<mark>X</mark>M 2□F Davs Hours Min. 530-74-2387 41 Director 0ct 6, 1965 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 No notified Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1275 Cape St. Clare 21409 Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 【No þ Specify Specify: 3 ☐ Widowed 4 X Divorced White Be Completed er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) If Health and Mentar 1932. Item 27 Is marked other the other than other traumatic event, the Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Lusby ဂ္ Jeanette Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Ciaccio/Friend 144 Overlea Drive Millersville, MD 21108 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State Metro Crematory, Inc. 8/3/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C Cremation Society of Maryland, Inc. Todd Dring Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, physician as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending UNKM 2 Accident investigation 07 1 ☐ Yes hours after death uneral Director: lace of injury - At hon building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide reet within 24 hours at To the Funeral D UNAVAILABLE Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO Name and address of person who completed cause of death (Item 23a) (Type, Print) ones

State Registrar 31. Date filed (Month, Day, Year)

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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death wi hoperament of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be.  To Be Completed by Funera	Widowed 4 375	iai i i cu	X No		res 2 X No		T dorto Titodi	11( 0101)		
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Division of Vital Records, P.O. Box 6876  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beneficial Certification: To Be Completed by Physician/Me		hysician: To the best of m	mination and							
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OCME	30. Name and address of person	who completed cause of	death (Item 2	(3a)						
0	Mary G. Ripple MD.	Deputy Chief Medi		iner 111	Penn Stree	t, Baltimo	ore, MD 2	1201		
State Registrar	DITE. II	7 2007 32. Re	ar's Signature	J. Ap	orter.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 03:15AM 2007 Alice L. Lydon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOCE B ALTIMORE Birthplace (State or Foreign Country). If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 15 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 216-10-2642 1 □ M 2/€ F 96 <sup>a</sup> 911 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location Show 10a, State 10b. County 10d, Inside City Limits at a or 28a-f shot be notified a MD Baltimore Director Middle River 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7052 Greenbank Road 21220 2 should be filed within 72 hours after death win and Mental Hygiene.
Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tailor Calvert Clothes 9th item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event Be Joseph Lucas Ursula Anderson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Liskey 6318 Wimbledon Court Elkridge MD 21075 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Holly Hill Cemetery 8/7/07 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HEART FAILURE burial-tran Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 ☐ Yes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 1 ☐ Yes 1 💢 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day,

State Registrar AMMER BE.
31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EAN CAROLINE LOOSER 12:30 PM 2007 AVG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KESVILLE Year If Under 24 Hrs. If Under 1 CARROLL FAIRHAUEN RET. Comm. If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 396-14-5935 1 □ M 2 X F Hours 83 **Director** MAR 11 WISCONSIN Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits CARROLL SYKESVILLE Funeral Director 1 Yes 2 □ No MO 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7200 3RO AVE 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene, important: If Item 27 is marked other than any injury or other traumatic event, the Mone. HOMEMAKER OWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TERRETT Goldaner ပ GEORGENE (JerhARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) 320 Sykesville Looser mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/2007 HAMPSTEAN, MD 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUM BRW FH & MON Co. 28 STKESVILLE ROOW ELDERS BURG-MO 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years Alzheimers disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s hy po thyroid is m 2 □ No To the Hospital or Attending Physician; 25. Was cas referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled PSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certific

illiam 31. Date filed (Month, Day, Year)

32. Registrar's Signature

1645 Libert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanki)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

D34849

Road

29d. Date signed (Month, Day, Year)

Eldersburg MD

2007

### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death **Physician** Yaar Poreth 419AM Jul 2001 /Medical 4a. Facility Name (If not institution, give street end number 4b. City, Town, or Location of Death Examiner 4c. County of Daath Future Care Lochearn Baltimore 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral**  Birthplaca (State or Foreign Country) Days Months 1□M 2∏F Director 78 Yrs 218-22-1906 Oct 28, 1928 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Marylan. I nent of Health end Mental Hygiene. 10a, Stata 10b. County 10c. City, Town or Location or 28a-f show 10d. Insida City Limits 7 is marked other than "netural", or itema 23a or 28a-f shor treumatic event, the Medical Examiner must be notified at MD Director Baltimore ty□ Yas 2□ No 10a. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 1 Cooperative Drive #311 21212 Funeral USA 12. Was Dacedent Evar in U,S. Armad Forcas? Was Dacedent of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: 1 Nevar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🗓 No ģ Specify: 3 ☐ Widowad 4 ☒ Divorced Specify: black Completed 15. Decedant's Education (Specify only highest grede completed) 16e. Dacadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Sacondary (0-12) Collega (1-4or 5+) 12 wireperson Westinghouse 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Judge Warren Hamilton Margaret Isabelle Cager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 in other tre Gertrude Banks/sister 9603 Artin Road #104 Randallstown, MD 21133-2459 20a. Method of Disposition 20b. Placa of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other plece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. ≖ ბ 4 X Donation 5 ☐ Other (Specify) 21. Signatura of Fune al Service Licensea Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 enn Entar the diseasa, or compl or heart failure. List only or plications that causad tha death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, one causa on each lina. Approximata Intarval Betwaan Onset and Death **Physician** Immediate Cause (Final disaase or condition rasulting in death) /Medical lea-Examiner Cance Due to (or as a consequence of): Examiner the death certificate be executed ettending physician and I for use as the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consaguance of): ete has been signed by the e page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 TYas 2 No 1 ☐ Yes 2 ☐ No Physicien: funeral director, Be 25. Was casa referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 2 211 No Other: 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 4☑ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of efter death. Director: After t 28d. Describe how injury occurred or Attending 1 🔀 Natural 5 Pending 2 Accident investigation 1 ☐ Yas 2 ☐ No the 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel D Hospital Certifying Physician: To tha best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier 29c. Licanse numbar 29d. Date signad (Month, Day, Year) July 31, 2007 D 37573 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) SCF Thell MD Main 25 St. 31. Data filad (Month, Day, Year) 32 Ragistrar's Signature Registrar

DHMH 16 Rev 6/95

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			For State Registrar		State	of Mary		epartm Certific				fental H	ygien Reg. N	211	37	252	23
	Physici	_	1. Decedent's Nam	e (First, Middle,	Last) Donna	a Lou	Ly	nch				2. Date of D Month		ay	Year	3. Time of	
ı	/Medi Examir		4a. Facility Name (1 Peninsula	1	give street and	number)	enter		City, Town, o	r Location	n of Death		4	c. County			
	Funeral Director		5. Social Security N 214-44-8	3308	5. Sex 1 □ M 2 🔀 I	7. Age (In	yrs. last birth	nday) If Ur Mon	ths Days	If Unde Hours	Min.	8. Date of E (Month, L Feb.	Day, Yea	r)	9. Birthp Cour	lace (State o	r Foreigr
	aryland show	_	Usual Residence of 10a. State	10b. County		100	c. City, Town								1	0d. Inside Ci	
	th the Marylar or 28a-f show e notified at	Directo	DE 10e. Street and Nu		issex				nview Zip Code				10g. C	itizen of V	Vhat Cour		- ZAJ NO
	23a ust b	a	32771 I	Kensingt	on Cour	ct				19	970		U	nite			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Marr  3 ☐ Widowed	ried 2☐ Marrie	Armed d 1 ☐ Ye If Yes,	ecedent Ever Forces? es 2 2 No Give or Dates:	in U.S.		ecedent of F specify Cub s 211 No			ecify Yes or N Rican, etc.)	10-		k, White,	an Indian, etc. ite	
8	tural	edr	o mad mad	15. Decedent's		T Dates.	16a. l	Decedent's	Jsual Occup	oation			16b.	Kind of Bu	ısiness/In	dustry	
Maryland 21215-0036	hin 72 e. an "ne Medic	plet	(Spec	cify only highest	grade complete	e (1-4or 5+)	-1 '	Give kind o life. DO NC	f work done T use retire	during ma d)	ost of work	ing	Ī			•	
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and	12 should be filed within 'n and Mental Hygiene. 7 Is marked other than "traumatic event, the Mec	Be	17. Father's Name	el R. Ro	•							e (First, Midd. eth M.			,		
Ž	should bd Me mark matic	2	19a. Informant's N	-			19b.	Mailing Add	ress (Street			al Route Num				Code)	
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Baltimore,	permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau			position  Cremation  5 Other (Spe		om State	Ob. Place of cemeters	, crematory	or other pla	· i		Date 2007		Location -	-		
Balti	permit. Departn Importa any Inju		21. Signature of Fi	uneral Service L U. R. Wa	ton fr.			Duda		: Fun	eral	Home o				nc. L222	
	Physician /Medical Examiner		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	a	at caused the on each line. to (or as a co	Sub	aville	mode of dyi	ng, such a	as cardiac	or respiratory	arrest,			Approximate Interval Bet Onset and I	ween Death
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8760,	cate be executed by sician and the burial-transit	dical Ex	resulting in death)	Last	d	to (or as a co	nsequence o	f): 					***				
P.O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown	? months? □ No	1 □ Li 4 □ Pr	outcome pf pove birth 2 regnant at time	Fetal death	3 □Ectop 5 □ Othe	ic pregnanc r (specify) _	у					te of delive	•	Year
	w requires that s been signed by should be deta	by	Part II. Other signi	ificant condition	s contributing t	o death but no	ot resulting in	the underfyi	ng cause giv	ven in Par	t I.			use cont	ribute to t	he cause of d	death? Jnknown
or Vital Records,	The law ate has b page 2 st	Completed											topsy rformed2	,   ;	Were auto prior to co death? 1 □ Yes	ppsy findings mpletion of ca 212190	available ause of
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or	≥ .º ₽	၉	1 Yes 2 ☐ 27. Manner of Dear		Hospital: 1	The patient ate of Injury	2 ER/Out		J DOA		Nursing Ho	ome 5 ☐ Re 28d. Describ		_		fy)	
O	ding F h. After funera	tion	1 Natural	5 ☐ Pending investiga	(A	Month, Day Ye	<i>ar)</i> In	jury M	28c. Inju Wo	rk? ]Yes 2[	ZDNo	Fall S			eu		
Division	o the Hospital or Attending Phithin 24 hours a ler death. o the Funeral Director: After the ompletely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be 28e. Pl	ace of injury - uilding, etc. (S	At home, fan Specify)	,-				28f. Location	(Street own, Sta	and Numb	_	al Route Num	
	e Hospita 124 hours e Funera letely fille	edical C	29a. Certifier (Check only one)		Physician: To xaminer: On th and n	the best of m	y knowledge, amination and				and place,	and due to th	ne cause	(s) and ma	anner as s	tated.	
	othin othic ompl	Ĭ.	29b. Signature and	title of certifier					29c. Licens	se numbe	r		29d. E	Date signe	d (Month,	Day, Year)	

State

DHMH 17 Rev 1/2001

Registrar

100 & Carroll Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Chris Snyder MD 100 & Car

31. Date filed (Month, Day, Year)

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Salisbury mo 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 16a h per fh 9870 8-16-07 vt.
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:10 P M 2007 Aug 5, Ernest Alvin Loveless, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Nov 29, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 1 M 2 □ F Yrs 213 38 1530 Washington DC 1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □No Maryland Prince George's Director Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 6417 Horseshoe Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Arroed Forces?
14 Dives 2 □ No
If Yes, Give
Year or Dates: 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2☐No Specify Specify White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7th Judicial Circuit filed within 7 I Hygiene. Chief Judge Elementary/Secondary (0-12) College (1-4or 5+) Circuit Court is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian V. Kershaw Ernest A. Loveless, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Barbara Holtz (Daughter) 9154 Preference Drive, LaPlata, MD 20646 ortant: If item 2 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 17, D2007 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State Clinton, Maryland Important: If any injury o 4 Donation 5 DOther (Specify) Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licenses Kierta D. m01284 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Kespiratory 30 day **Physician** /Medical Due to (or as a consequence of Examiner sendo monos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to ( as a consequence of): mp hys ema Box 68760, attending physician Physician/Medical as the b IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Anemia 2 □ No 3 Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No trach 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive, GOG Clinton, MD 20754 Hakimimo

Registrar

State

31. Date filed (Month, Day, Year)

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear Physician 31 2007 Robert Lerov Lewis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAUTIMORE SAINT AGNES HEALTHCARE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 M 2 ☐ F 212-16-0207 86 06/28/1921 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r 28a-f show notified at 1 XYes 2 □ No n/a Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or Items 23a or Exa⊡lner must be Funeral 2143 Parkslev Ave 21230 United States Pages 1 and **2** should be filed within 72 hours after death <sup>1</sup> nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 170ct42

If Yes, Give Year or Dates: 22Sept53 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the 8 Transportation Truck Driver If item 27 Is ⊓arked other or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Reeves Thomas A. Lewis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2143 Parksley Ave. Baltimore, MD 21230 of Disposition (Name of Date 20c. Location - City or Town, State Thelma A. Lewis / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Department o Important: If any Injury or once. 4 Donation 5 DQther (Specify) Cedar Hill Cemetery 08/04/2007 Baltimore, Maryland 22. Name and Address of Facility Ambrose Funeral Home of Lansdowns 21. Signature of Funeral ice Licens 2719 Hammonds Ferry Rd Lansdowne, Maryland 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) hRONIC RenAl **Physician** /Medical Due to (or as a consequence of): Examiner heroscheroti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Disease OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 Probably Be Completed perlension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes Division or Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier My SICIAN D005455 200+ Name and address of person who completed cause of death (Item 23a) (Type, Print) BURKE, JR, MD ERIL 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf 9870 8-7-07 vt.
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician Williams Barnes Miller . Frances 31 2007 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nursing Home Bethesda Montgomery Collingswood if Under 1 Year | if Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 1 F Hours 218-34-5261 102 Director 05-16-1905 DC Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 XYes ⊋√No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 5503 Charlcote Rd. 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ENo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene.

To 1s marked other than "natural", or iten the traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archy W. Barnes Lida ျ Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Swing Daughter 10503 Graeloch Rd. Laurel MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 8-2-2007 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Ser. 21. Signature of Funeral Service Licenses ma1358 933 Gist Ave. Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dehudration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner angestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Examiner that the death certificate be executed anemia attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 🗆 No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D30132

DHMH 17 Rev 1/2001

7

State Registrar

ORIGINAL

4812 Physicians Ln.#161 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mi Rita Gihosh

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2007 10:00 Mecca 30 /Medical Jane Louise 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bethesda If Under 1 Year | If Under 24 Hrs. Manor Care Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1□ M 2√xF 87 Director <u>Pennsyl</u>vania 459-34-1173 06-06-1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1-√Yes 2 No MD Director Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 USA Funeral 6530 Democracy Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 점 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrati</u>ve Assistant D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Lloyd Middleton Julia Hardnacke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 576 N. Bellflower bl. #241 Long Beach CA. 90814 Son Lloyd J. Mecca 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 8-2-2007 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility 933 Gist Ave. Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed that initiated events resulting in death) Last and the burial-tran Division or Vital Records, P.O. Box 68760,ິ Due to (or as a consequence of): physician Physician/Medical as attending p IF FEMALE: use If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ NO 24a. Was an autopsy performed 1□ Yes 2₽1 certificate 2E No the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural injury 1 TYes 2 □ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\mathcal{O}_{\prime}$ Dr. Ste, 201 Rockville MD 20850 Truong Bao
31. Date filed (Month, Day, Year) 9715 Medical Center 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ATHERINE Month Year MORIZIS 5 2007 /Medical 4a Facility Name (If not institution, give street and number) Genesis Loch Raven 4b. City, Town, or Location of Death 4c. County of Death Examiner Balitmore Baltimore 7. Age (lg ys. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 219-10-6756 8. Date of Birth (1921) 144/1918 Birthplace (State or Foreign
 Country) **Funeral** 1 □ M 20%F Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28a-f show other than "natural", or items 23s or 28s-1 showent, the Madical Examiner fourt be notified at MD 1 Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 712 East Seminary Ave. Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Never Married 2☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White δ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Bakery 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary (Secondary (0-12) College (1-4or 5+) Secretary 17. Father's Name (First, Middle, Last)
John Mc Nally 18. Mother's Name (First, Middle, Maiden Surname) Zimmerman is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 East Seminary Avenue Towson, MD 21286 19a. Informant's Name/Relationship (Type, Print)
Phyllis Rogers/Daughter permit. Pages 1 end 2 s Department of Health ar Important: If itsm 27 is eny injury or other treu once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory Inc. 2007 20a. Method of Disposition Adg 8 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 21. Signature of Funeral Service Licensee MOLYUZ Tremation and afternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC AMMITHMIA /Medical Due to (or as a consequence of): Examiner SCVV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed HRONIC resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ettending p for use as IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMEN TIA 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 -No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Fmath Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To this After thi 27. Mann of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and titte of certifier 29d. Date signed (Month, Day, Year) 29c. License number Jekodo mo 032717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5720 EMGE 120 10 FENNANDO DEL6MAN BALTIMERE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of Maryland / Departn	nent of Health and	Mental Hygien	е
				cate of Death	Reg. Ne	2007 25220
		.0	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
4	Physici		Ronald L. Mueller		Month Da	4. 2007 6:25 A M
ļa.	/Medio			City, Town, or Location of Dear		c. County of Death
	LAGIIII		Saint Joseph Medical Center	Tows		Baltimore
-	Funeral			Inder 1 Year   If Under 24 Hrs		9. Birthplace (State or Foreign
п	Director		216-30-0525 1MM 20F 74 Yrs. Mol	nths Days Hours Min	(Month, Day, Year)	Country)
	ס		Usual Residence of Decedent		10 10 110	s Irlantiana
	rylan how at		10a. State 10b. County 10c. City, Town or Location	1		10d. Inside City Limits
	Mal a-fs	햕	md Baltimore Carne	J		1 □Yes 2 MNo
	or 28	Director		f. Zip Code	10g. Ci	itizen of What Country?
	h wit		2506 Hillford Drive	31234	1	15A
	72 hours after death with the Maryland natural", or items 23a or 28a-f show ileal Examiner must be notified at	Funeral		Decedent of Hispanic Origin? (5, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
9	after or ite nine		1 Never Married 2 Married 1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 2 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Yes 3 Married   1 Y		To Rican, etc.)	Black, White, etc.
21215-0036	ral",	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	es 2⊠No <i>Specify:</i>		Specify: White
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21	within lene. than "	헏	Elementary/Secondary (0-12) College (1-4or 5+)	of work done during most of wo OT use retired)	rking	
2	er th	5	12 Service	technicio	an Em	IR Services
nd	e filed value Hygie	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maider	n Surname)
/la	ould be Mental arked o	户	Louis C. Mueller Jr	Their	na. Edna	. Oed
Maryland	and and sum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add	dress (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
	1 and 2 Health em 27 i		Carol Mueller - wife 2506 H	Ilford Drive	Baltimore	Md 21234
ore.	of He		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  cemetery, cremator	(Name of vor other place)		ocation - City or Town, State
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Baltimore,	- 4 4 4 t		11. (11011000	101111111111111111111111111111111111111	1 200 11 111	nonium, Md ithon Services-Parkville
m	permi Depar Impo any Ir once.		Sinvery Janothy 8800		ipel & Crema	ition Services - Parkville
	(		23a. Part1. Enter the disc set, or complications hat caused the death. Do not enter the shock, or heart fail rs. List only one cause on each line.		c or respiratory arrest.	Md 2/234 Approximate
	Dhusisian		Immediate Cause (First)			Interval Between Onset and Death
) ,	Physician /Medical		resulting in death)	ALL CELL LU	NG_CANCER	
	Examiner		Due to (or as a consequence of):	•		
		<u>-</u>	Sequentially list conditions, if any, leading to immediate b.			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the conditions of the cause of the conditions of the cause of the conditions of the cause of the conditions of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the caus			
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68760,	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	edical	d			
×	certif ding se as	Me	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome pf pregnancy			
Box	atten for us	ian	in the past 12 months?	oicpregnancy	1	23d. Date of delivery  Month Day Year
P.0.	the thed	Physician/M	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Othe 9 □ Unknown 9 □ Unknown	r (specify)		mona, Bay roa
٣.	hat ti d by detac	문	Part II. Other significant conditions contributing to death but not resulting in the underly	ing agusa giyan in Bart I	220 Did tehana	constitute to the course of death 0
Vital Records,	ires t signe	þ	rates. Such significant containers contained by death but not resulting in the underly	ing cause given in Fait i.		use contribute to the cause of death?
0	w requir been si should	Completed			1 Yes 2	□ No 3 □ Probably 4 □ Unknown
ec	law las b	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The ate h	Ö			performed? 1 Yes 2 No	death?
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_	ding Physician: The n. After this certificate ha funeral director, page	To	Hospital:	□ DOA Other: 4 □ Nursing H	lome 5 ☐ Residence	6 □Other (Specify)
Division or	ng PI		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	
<u></u>	tendir leath. tor: At the fu	atic	2 ☐ Accident investigation M	1 ☐ Yes 2 ☐ No		
<u> </u>	or Atterdate de Directo	Certification:	3 ☐ Suicide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office		nd Number or Rural Route Number,
$\bar{\Box}$	salor safte	E	Danially, co. (opeary)		City or Town, State	<del>)</del>
	hour hour iner		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	rred at the time, date and place	e, and due to the cause(s	) and manner as stated.
1	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investignand manner stated.	auon, in my opinion, death occi	urred at the time, date an	d place, and due to the cause(s)
(	To the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confi	ž	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
	d		> goginder / mehlamo	D41410	Ayou	ust 42, 2007.
	1, 1	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(	)
	411			DRIVE TOWS	ON MARYLAN	IT) 21204
	Stat	е	31. Date filed (Month, Day, Year)  32. Registrar's Signature	MINTAL I CAMO	APPLE FILE	II LECT
			ALIO 0 17 2007 Va. 60 A.	- M. A.		

7. Age (In yrs. last birthday)

10c. City, Town or Location

GLEN BURNIE

51

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

GLEN BURNIE

10f. Zip Code

21061

1 ☐ Yes 2 💆 No

If Under 1 Year | If Under 24 Hrs.

Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

ANNE ARUNDEL

10g. Citizen of What Country?

UNITED STATES

Specify:

14. Race - American Indian.

WHITE

Black, White, etc.

MARYLAND

8. Date of Birth (Month, 12), Year)

1956

JUNE <del>8,</del>

8:00 A M

**Funeral** Director the Maryland 28a-f show a or 28a-f sh Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ns 23a must b Baltimore, Maryland 21215-0036 ō "natural" other than "natu vent, the Medical 7 Is marked othe traumatic event, Health tem 27 I

**Physician** 

/Medical

Examiner

**OLGA** 

10a. State

Director

by Funeral

Social Security Number

220-56-9863

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

808 BENTWILLOW DRIVE

10b. County

MARYLAND ANNE ARUNDEL

808 BENTWILLOW DRIVE

1 Never Married 2 Married

3 Widowed 4 Divorced

Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STEPHEN D. MALLORY JUNE VERA RIER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 DORCHESTER RD., GLEN BURNIE, MD 21061 SHELLY THOMPSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot AUGUST 8 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State EPIPHANY CEMETERY 2007 4 □ Denation 5 □ Other (Specify) ODENTON, MARYLAND 22. Name and Address of Facility KIRKLEY-RUDDICK 421 CRAIN HWY., e of Foreacal Servi 21. Signat FUNERAL HOME, P.A. S.E., GLEN BURNIE, Als 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 Runic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit D Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached i 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury n 24 hours after death.

ne Funeral Director: At bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hou

To the Fune
completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14753 AUGUST 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. KROOPNICK, M.D., 1406 CRAIN HWY., SUITE 108, GLEN BURNIE, MD 21061

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 7 2007

. Registrar's Signature

**Physician** /Medical Examiner

Examiner æ

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

h and Mental

mit. Pages 1 and 2 partment of Health a cortant; If Item 27 is injury or other trains

permit. Page Department of Important; If any injury or once.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

sician and burial-trans

IF FEMALE:

Meghan

A.

3 Date filed (Month, Day, Year)

Arnold MD;

AUG 0 7 2007

nding physician as signed by t d be detach within 24 hours are: ....
To the Funeral Director: Aft

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

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Part II. Other significant conditions co		-	ng cause given in Part I.			se contribute to the cause of death? □ No 3 □ Probably 4 ▼Unknown
				24a. Was a autops perform	sy med?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only on	e)	
1 Ves 2 No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Reside	ence 6	3 ☐Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fac fy)	ctory, office	28f. Location (St City or Town	reet and n, State)	d Number or Rural Route Number, )
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29b. Signature and title of certifier			29c. License number	2	9d. Date	e signed (Month, Day, Year)
Meghan a. aun	1		RBJ-000	1	14157	7 7 2007

BALTIMORE

MP

21224

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EMTERN AVENUE

32 Registrar's Signature

07	05956	

State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Fig. 16.  Consider State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Middel State of Death  General View Antoninette Martin  General View Entrance of Teach State of Death  Angular 3, 2007  Teach State of Death  Angular 3, 2007  Teach State of Death  Angular 3, 2007  Teach State of Death  Angular 3, 2007  Teach State of Death  Angular 3, 2007  Teach State of Death  Angular 3, 2007  Teach State of Death  Angular 3, 2007  Teach State of Death  Teach State of Death  Teach State of Death  Angular 11, 2007  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of Death  Teach State of	07-05956					rint in B								egible	е.	
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Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			MA	19	Un	10				O.C.	M.E.			Aug	gust 4, 2007	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Month VIR6INIA 1700 August 2, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 X F Min. 02-02-1942 Director 65 218-36-5786 Kentucky Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Hemingway Drive 21014 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status درنان کا Should be filed within 72 hours after ut and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Anderson Bobby McVey Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trai once. 313 Hemingway Drive Bel Air, MD 21014 Lawrence S. Maloy (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gar. 08-08-2007 Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Lice Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician NONSMALL CELL LUNG CAMCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Maley Viral niam coogsogy & Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOC228412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP NINATPUMIN, 6025, ATMOOD RD, BEL AIR MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Knox Phillips Nash P M 07 12 2007 8:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Sex. 2□F 8. Date of Birth (Month, Day, Year) Months Days Hours 256-34-7110 82 New York 1-7-1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Prince George's Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 USA 3368 Chillum Rd. #202 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married Married 1 □ Yes 2 1 No Specify. Specify:black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Phillips Earl Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3368 Chillum Rd.#202 Mount Rainier, MD 20712 Gwendolyn Nash/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 8/4/2007 Beltsville, MD 21. Signature of Funeral Service Licensee moi358 22. Name and Address of Facility MD 20910 Rapp Funeral& Crem. Sv.933 Gist Av.Silver Spring Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Days disease or condition resulting in death) Due to (or as a consequence of): Tract Infection drinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as \* consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify)

Examiner Hospital or Attanding Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physicien and the certificete has been signed i rector, page 2 should be det this nours after death narel Director: A filled in by the fi within 24 hours at To the Funeral Completely filled i

**Physician** 

/Medical

**Examiner** 

Completed by Funeral Director

Be

2

Examiner

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s or 28e-f show say highry or other traumatic avent. The Medical Examinat must be notified at once.

**Physician** 

/Medical

use as the burial-transit

Baltimore, Maryland 21215-0036

Physi	9 Unknown	9□ Unknown	1100	,, ,,		
þ	Part II. Other significant conditions of		sulting in the underlying	g cause given in Part I.		se contribute to the cause of death?
Completed	Myscardial I	infarction			24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
10	1 ☐ Yes 2 No	Hospital: Apatient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 Residence	G ☐ Other (Specify)
ation:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injur	y occurred
Certifica	3 Suicide 6 Could not b. 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		ory, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number, )
edical (	(Check only one)	ysician: To the best of a y kno niner: On the basis of examina and manner stated.	owledge, death occurration and/or investigati	ed at the time, date and place on, in my opinion, death occi	e, and due to the cauta(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
ž	29b Signature and title of certifier			29c. License number	29d Dat	e signed (Month Day Year)

D32332

9801 Georgia Ave # 220 Silver Spring, MD 20 910 istrar's Signature

29d. Date signed (Month, Day, Year)

Registrar

29b. Signature and title

ame and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 4, 2007 8:15 A M Janette Louise Nyce /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2214 Geist Road Glyndon Baltimore 8. Date of Birth (Month, Day, Year) Nov. 14, 1948 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗙 F 220-56-3332 58 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" -- any injury or other traumatic executions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Director Maryland | Baltimore Glyndon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2214 Geist Road 21071 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall K. Steele, Jr. M.D. Elsie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas A. Nyce (husband) 2214 Geist Road, Glyndon, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial ▲2 ☐ Cremation 3 ☐ Removal from State St. Thomas Cemetery 08/09/2007 | Garrison, Maryland n 5 Other (Specify) 4 □ Donat 22. Name and Address of Facility Ruck Towson Funeral Home, of Funeral Service Licensee 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 W No 23d. Date of delivery 3 □Ectopic pregnancy Day Month Year signed by the at d be detached for 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 | Yes 2 | 1 | Yo မ 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No 2 Accident I Director: A in by the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Division or Vital Records. P.O. Box 68760. within 24 hor To the Fune

31. Date filed (Month, Day, State Registrar

29b. Signature and the of certifier

Ritchio Huy Arnold

ORIGINAL

29c. License number

16964

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1509

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death orien-Har 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9/23/ Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 218-14-1038 Year) 1□M 2XF Hours Min **Director** Marylano Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) elephone 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be polembies ပ္ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State ALTIMORE 21. Signature of Funeral Service Licensee Forest Hill, MD 2050. 23a. Part. Enter the diseast, or compiliations that salised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List by yone cause on each line. tion Services Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPERCALCEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The law 24a. Was an autopsy Vital 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ASSISTED Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Iniury death. 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or

Registrar

State

SURESH SUKCS,.

31. Date filed (Month, Day, Year)

AUG 622 S. UNION AVE, HAVRE DEGRACE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA 32. Registrar's Signature

DHANTANI

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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	for State	State of Maryland / Dep		ientai Hygier	ne 2007 25227
	Registrar		rtificate of Death	Reg. N	6.001 20201
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/Medical	Marian E.	Preston		Auf. o	4 2007 11:00 M
Examiner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	0 4	4c. County of Death
	5. Social Security Number 6. Se		) If Under 1 Year If Under 24 Hrs.	1	saltimore
Funeral Director		M 204F 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Usual Residence of Decedent	07		6-2-193	23 Maryland
yland	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
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r dea	11. Marital Status		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36 serie afte	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	r tiouri, oto.,	
21215-0036 21215-0036 ed within 72 hours a ygiene. ygiene "naturel", o yer than "naturel", o t, tre Medical Evair. Completed by	3 Widowed 4 Divorced	Year or Dates:			Specify: White
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d d d d d d d d d d d d d d d d d d d	17. Father's Name (First, Middle, Last)		memaker 18 Mother's Name	(First, Middle, Maide	t home
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Baltimore, Maryland 21215-0036  Permil. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaluation and injury or other traumatic event, the Medical Evaluation and injury or other traumatic event, the Medical Evaluation and Director To Be Completed by Funeral Director	Charles A. Presto	1	CONTRACTOR OF THE CONTRACTOR OF	Paltin	0(n M d 3/33/
Te, 1 au Item	20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 20c.	Location - City or Town, State
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Bal permi Depa Impo any ir	Limberty 11	2 11/1/2 8	vans Funeral Chap 800 Harford Road	el & Crema	tion Services - Parkville le Md21234
	23a. Part1. Enter the disease, or compri	dations that caused the death. Do not en	ter the mode of dying, such as cardiac of	r respiratory arrest.	Approximate
Dhysisian	Immediate Cause (Final				Interval Between Onset and Death
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th ce th ce r use	250. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Bectopic pregnancy		23d. Date of delivery
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ecc law r as be 2 sh				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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ing P	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time o	f 28c. Injury at Work?	28d. Describe how inju	ury occurred
Sio	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division of Vital Records, or Attending Physician: The law requires I after death. Director: After this certificate has been signe in by the funeral director, page 2 should be certification; To Be Completed by	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
pital ours a sral filled	00-0-45				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification; To Be Completed by Physician/Medi	29a. Certifier  (Check only one)  1 Certifying Physical Examination	ician: To the best of my knowledge, deather: On the basis of examination and/or in	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(sed at the time, date an	s) and manner as stated. Indiplace, and due to the cause(s)
thin the orthe orthe orthe orthe	29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month, Day, Year)
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1.9	20 Nome and address of assessment	policiad course of division do ) =	0000	7-1	uj. 4200/
Q ·	Su. Harrie and address of person who co	npleted cause of death (Item 23a) (Type,	Calor of 11	20) 2	0 0+in 20 2120
State	31. Date filed (Month, Day, Year)	32. Segistrar's Signature	7	JUZU	2007
Registrar	AUG 0 7 20	17 Delin St A	and it		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #29c, per DVR, g870, 8/7/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Frank Lewis Purdum, Jr. AAUGUST 4. 2007 1:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. NoV. 30, 1945 Center Baltimore 6. Sex 1 M 2 F 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 215-44-1625 61 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 □Yes 2 □Wo Director MD Baltimore Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 1503 Walker Road 21053 USA Funeral 12. Was Decedent Ever in U.S. Asmed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: þ 3 Widowed 4 Divorced "natural", Completed er than "natur ; the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Information Elementary/Secondary (0-12) College (1-4or 5+) Technology Specialist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Frank Lewis Purdum, Sr. Elizabeth Eckhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Catherine E. Purdum 1503 Walker Road; Freeland, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) Parkwood Cemetery 8/8/07 Parkville, MD 21. Signature of Funeral 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MYOCARDIAL INFARCTION MINUTES /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl for use as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 FR/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

011

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 0 7

DHMH 17 Rev 1/2001

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEAUVOIS

29c. License number

7601 OSLER DRIVE TOWSON, MARYLAND

D 62551

29d. Date signed (Month, Day, Year)

4 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06 ay 2007 ear August Frank Charles Pipesh, Sr 12:30 P M Northwest Hospital Center 4b. City, Town, or Location of Death 4c. County of Death Randallstown **Baltimore** 8. Date of Birth (Month, Day, Year) May 31, 1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Months Hours Min. 362-26-3768 1 M 2 □ F 83 Michigan Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland **Baltimore** Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3668 Clifmar Road 21133 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married Married 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Assisted Living Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Pipesh Margaret Genaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Pipesh (Spouse) 3668 Clifmar Road, Randallstown, Maryland 20c. Location - City or Town, Stat 21784 20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Lake View Memorial Pk 08/09/07 Sykesville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licens 1400 333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying bause Uniscase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Small bowel 1 Probably 4 Unknown COPI 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Ho 24a. Was an autopsy performed 1□ Yes 2 Z No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

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death.

To the Hospital or Attenct within 24 hours after death To the Funeral Director:

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Examiner

**Funeral** 

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Physician/Medical 9 ☐ Unknown 5 Completed Be 1 ☐ Yes P Certification: 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

25. Was case referred to medical examiner? 27. Manner of Death

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D65843

August 6, 2007

Kerson who completed cause of death (Item 23a) (Type, Print)
Kafroun, , 540, Old Court Rd, Randallstown, HD 21133 Abdallah 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1 per PHYS C870 8/7/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Pappafotis 2. Date of Death 3. Time of Death **Physician** Month, 2112 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 F Months Days Hours 278-22-6512 80 PA Director 2/7/1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 👿 No Directo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8937 Twin Ridge Drive 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold McClure Garnet ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8937 Twin Ridge Dr., Glen Burnie MD 21061 Mr. Spero J. Pappafotis/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, 7/25/2007 Glen Haven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Tuneral Source Licensee M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespirata Se on Chi **Physician** /Medical Due to (or as a consequence of Examiner Ran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 eutopsy performe After this certificate AN No 1 ☐ Yes 2 No 1∐ Yes or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 2/438 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY ANNAPONS MO21401

DHMH 17 Rev 1/2001

Registrar

Registrar's Signature

Day,

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2007

State of Marylai	nd / Departmen	it of Health an	d Mental	Hvaiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2007 Carmen C. Roig August 3:56 p <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, MAY 17 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2X F 1908 582-72-7782 99 Director Puerto Rico Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heaith and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 X No Director **Baltimore** Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 17 Farnham Way 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No 2 3 XWidowed 4 ☐ Divorced Puerto Rican White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Casto Luis Calderon Rivera Maria Julian Garcia Pinero ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maria Roig Ferrer - daughter Department of Health Important: If item 27 any injury or other tr 17 Farnham Way, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/6/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility. Cremation Society of Maryland, Inc. Williams - Hnh 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALZHEIMER'S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown ils certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 24 hours after death Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO D16619 ust 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CORAZON VERGARA -SOARES, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Lic		22. Name and Address of F		GUARRA	tonsolle	MARY HAVE
<u> </u>	89 = 8		Jacquy m.	Cerebre	3405 W, FR	Anklin	St. BA	Himore, 1	ud 21249
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Вох	ath ce ttendi	lan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	/ eath 3 □Ectopic pregnancy			23d. Date of delive	•
	The law requires that the death cer te has been signed by the attendir page 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	h 5 ☐ Other (specify)			Month	Day Year
Records, P.	s that ined by e deta	by Ph	Part II. Other significant conditions	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?		
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	spital		29a. Certifier  (Check only 2   Medicel Exeminary of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
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	.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
	1	+	Dr. Marti	1 Edelmar	a) (Type, Print)	PENE	St P	Da Ita	MA DIDA
	Stat	ė	31. Date filed (Month, Day, Year) AUG 0 7	32. Pigistrar's Signature					1001
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland Poepartment of Health and Mental Hygiene

Certificate of Death Reg. No. 2007 Year 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JESUS 12.55 RUBIO 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Ht Washington Pediatric Hospital BALTIMORE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 6. Sex Funeral Months Days Hours t M 2□ F Director 213-77-4154 10 Sept. 19,2006 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tem 27 is marked other than "natural", or items 23s or 28s-f show other trsumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔯 No Essex Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pernit. 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Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Torres Jose F. Rubio 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1169 Punjab Drive Essex, Maryland Jose F. Rubio (Father) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/1/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) Hilltop Service Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List poly one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) END STAGE LIVER DISEASE 3 mo Examiner Due to (or as a consequence of): Physician/Medical Examiner 6 mo CHOLESMASIS or Attending Physician: The law requires that the death certificate ba executed physician and s tha burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 9 mo SHURT BOWEL SYNDROME Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): 9 mo NECROMZING ENTEROCOLITIS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown PREMATURITY þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CHROMIC LUNG DISEASE NA ANTHIA THROM BOCY TO PENIA 1□ Yes 2□No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 101 Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Dey Year) funeral ar death. 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendi within 24 hours aftar death To the Funeral Director: A completely filled in by tha f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 31/07 lefarione D0052349 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Mt. Washington Peds Hospital, Too W Rogers Ave Baltimore MD, 32. Signature 31. Date filed (Month, Dey, Year) State AUG 0 7 2007 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL ALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB **7, 1**950 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F 048-44-3811 57 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at show MD Baltimore Directo Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 2107 Oak Lodge Rd 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If item 27 is marked other th
any Injury or other thereas Attorney / Musician Family Law / Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Vincent Silvia Mary Elizabeth Hale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Emerald Silvia/Daughter 1229 Dwight Way Berkeley, CA 94702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory, Inc 8/4/07 21. Signature of Funeral Service Licensee Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD C. Todd Dring Lec 23a. Part1. Enter the disease, or con dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed

Division or Vital Records, P.O. Box 68760 signed by the attending physician is detached for use as the buria funeral director, this After t

To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After

Be

Certification: To

25. Was case referred to medical examiner?

5 Pending investigation

AUG 07

Could not be determined

1 Yes 2 No

27 Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day,

Natural

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

2 ☐ ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23d. Date of delivery

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

pertormed:

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

0831

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Betweer Onset and Deatl

Year

4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

Rhode Island

AM

Year

14. Race - American Indian,

Black, White, etc.

Specify: White

2007

4c. County of Death

N/A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

North 32. Registrar's Signature

Inpatient

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CORINE SCIPIO 9.50 PM AUGUST 02 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARROR HOSPITAL BALTIMORE 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign Country), 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F Yrs Director outh Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 Yes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: ٥ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) al permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type./Print) (SDn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2007 1 Burial 2 □ Cremation 3 □ Removal from State ansdowne, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart killure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro Vascular accident Approximate Interval Between Onset and Death **Physician** 1 week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Days to for as a consequence of burial-tran and Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached t a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rena 2 No 3 Probably 4 Unknown 1 X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy Pertension 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2⊠ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

P.O. Box 68760 Division or Vital Records,

Registrar

31. Date filed (Month, Day, Year)

-Hamati



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August 02

2007

# P.O. Box 68760 Division or Vital Records.

Baltimore, Maryland 21215-0036

**Physician** 

Examiner

**Funeral** 

Director

28a-f shov

Director

/Medical

MD

other traumatic event, the Medical Examiner must be notified at 'natural', or items 23a or Funeral 1 ☐ Never Married 2 ☐ Married <u>م</u> 3 ☐ Widowed 4 Z Divorced Completed than Elementary/Secondary (0-12) Department of Health and Americal Pygien Important: If Item 27 is marked other than any injury or other trainment. 17. Father's Name (First, Middle, Last) Be Ernest S. Santesse Sr. ပ 19a. Informant's Name/Relationship (Type. Print) Tony Santesse /son 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit physician s the burial Physician/Medical attending ph IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No the detached 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed has Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending hin 24 hours after death. the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 August 2007 30. Name and address of prson who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE Baltimore. Ashlugh 4940 Dr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:48 P<sub>M</sub> Day **Physician** 2007 Marlene M. Snyder August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🗙 F 68 213 36 4227 Director Jan.14,1939 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 XNo Director Maryland | Baltimore Dundalk 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number death with 21222 7844 Kavanagh Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☒ No Specify. Specify: White 5-0036 Completed by 3 XWidowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 2121 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bingo Operator Bingo Hall 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) Be Leona Baker Is marked Martin Lorden 2 Marv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trains Kimberley Hare (Daughter) 8006 Kavanagh Rd. Baltimore, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐Removal from State Gardens Of Faith Cemetery 8/8/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. ture of Funeral Service Licensee 9 23a. Faht. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one carried on each line. <u>1407 Old Eastern Avenue Essex, Maryland 21221</u> Approximate Interval Between Onset and Death Immediate Cause (Final 2 Months **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 9 ☐ Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy page performe death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours arer death. 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number

State Registrar

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31. Date filed (Month, Day,

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29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STREE

DZ683 DroPaul 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 3, 2007 7:10 A M Schaaf /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3405 Meredith Ridge Road Phoenix Baltimore 8. Date of Birth (Month, Day, Year) f Under 24 Hrs Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F Director 146-16-6983 June 1, 1923 Holland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2 🙀 No **Funeral Director** Maryland **Baltimore** Phoenix 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 3405 Meredith Ridge Road 21131 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Computer Technology/ Elementary/Secondary (0-12) College (1-4or 5+) Information Technology 12 Electrical Engineer 02 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Is marked ot Pages 1 and 2 should be John Schaaf Hilda Smid ٩ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If Item 27 Is or other tra Stephen Schaaf/Son 970 Hope Street, 2D, Stamford, CT 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. 1 ☐ Buriai 2 puoleina... 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8/6/07 Catonsville, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 yan ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immedia e Cause Final Physician disease resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1☐ Yes 2 No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 À Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) .0

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark A. Lamos, M.D. Schilling Road, Cockeysville, MD

31. Date filed (Month, Day, Year) AUG 0 7 2007 2. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month **Physician** August 3, 6:13 РМ Linda Jean Schneider /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospice of Baltimore Gilchrist Ctr. Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 19,1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕠 F 213-44-9918 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1√ Yes 2 No Examiner must be notified Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3151 Woodring Avenue 21234 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after of lealth and Mental Hygiene. In 27 is marked other than "natural", or itel 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No white Baltimore, Maryland 21215-0036 Specify. Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) J Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfred White August Munk ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau husband 3151 Woodring Avenue; Baltimore, MD 21234 Robert Schneider 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation Hilltop Service Corp. 8/6/07 Towson, MD 5 ☐ Other (Specify) 21. Signature of Fu 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one arons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metastat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 200 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 2 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 W. Tuwsantown 32. Registra 31. Date filed (Month, Day, State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#31 per DVR C870.7 WS State of Maryland Pepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** <u>a</u> <sup>M</sup> Robert Chester Smith 8 4 2007 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 606 Millwright Crt. #13 Millersville Anne Arundel If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Yrs 213-36-7098 Director 67 8/19/1939 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at MD Millersville Anne Arundel 1 ☐ Yes 🐉 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 'natural", or items 23a or 21108 606 Millwright Crt. #13 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married ☐ Yes 2 🔀 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4or 5+) Stockroom Liquor Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Smith Jr. Mae Montaque ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any Injury or other trau Mrs. Edna Jean Marsteller/Sister 1000 Stoney Ln., Crownsville Md 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Creamation 8/6/2007 Stevensville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee 1 Second Ave SW, Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition DOUNUA **Physician** Sem disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1∐ Yes or Attending Physiclan: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 29a, Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and e of certifier no completed cause of death (Item 23a) (Type, Print) MA

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State Registrar OUL

31. Date filed (Month, Day, Year)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SIDNEY HAROLD SINGER hd 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bal hwore Cry Under 1 Year If Under 24 Hrs. J altmore N/A 6. Sex ) 8. Date of Birth (Month, Day, Year) 02/15/1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 070-20-2165 78 NY Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7621 CARLA ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 17 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1□Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) I and 2 sho Id be filed within Health and I ental Hygene. **OWNER JEWELRY** permit. Pages 1 and 2 sho Id be filed Department of Health and Nental Hyge Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be SINGER OLGA ZIEGLER **HENRY** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY SINGER / WIFE 7621 CARLA ROAD, BALTIMORE, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARY CEMETERY Injury 5 ☐ Other (Specify) 08/06/2007 | OWINGS MILLS, MD 22. Name and Address of Facility Signature of Funeral Survice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that aus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lacil line. Immediate Cause (Final AShY80, Tim

Due to (or as a consequence of): **Physician** As WK ING AMONIC disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9☐Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fun 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KE5 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELVEDEKE 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 Year **Physician** AUGUST ABBE SUSAN STAHL 4:46 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs, last birthday) **Funeral** Days 1 □ M 2 🙀 F 56 072-46-4566 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD BALTIMORE REISTERSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 42 FRANKLIN VALLEY CIRCLE 21136 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSDAL DISKIN STESSA MARVIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 42 FRANKLIN VALLEY CIRCLE - REISTERSTOWN, MD 21136 RANDALL STAHL / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 08/06/2007 REISTERSTOWN, MD BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mart 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER WITH META sreast **Physician** /Medical Due to (or as a consequence of) Examiner Sactumitally list condificas, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9∏I Inknown 9 Unknown After this certificate has been signed by inneral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Division or Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Intle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aria 31. Date filed (Month, Day, Year) State AUG 0 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #18, perFH,C870, 8/7/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month :30 PM /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTH CENTER **PIKESVILLE** BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 10/19/19/12 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M 207F 216-01-3345 94 Yrs. Director GERMANY Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28e-f show r than "natural", or Items 23e or 28e-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 725 MT. WILSON LANE 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) Be MATHIBA Mathilda HERMAN **GOLDSMITH** HERRMANN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA ASTRACHAN/DAUGHTER 1700 BY WOODS LANE - STEVENSON, MD 21153 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State HAR SINAI \*4 ☐ Donation 5 ☐ Other (Specify) 08/05/2007 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's **Physician** Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit completely filled to by the funeral director, page 2 should be detached for use as the burist-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 9 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: ္ရ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of !njury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural s after dea. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kalen L. Balitt, M.D. 20058676 August 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 old court Road suite 301, Baltimore, MD Karen L. Babitt M.D. 31. Date filed (Month, Day, Year) 32. Registre's Signature State

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Registrar

2007 ▶

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 **Physician** Month 27, 5:57 AM M Ju<sub>1</sub>y Olin B. Tharp Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bryans Road Charles 2133 Boxwood Circle If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 12, 1931 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 76 Director 579-42-1121 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or Items 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Charles Bryans Road Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20616 USA 2133 Boxwood Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CIA <u>photo technician</u> other injury or other treumatic event, permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 is marked oth any lighty or other treumstic event sons. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Olin Braxton Tharp Sr Genevieve Atha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Osterman/daughter 2331 Boxwood Circle Bryans Road, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libensee de Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ØRON Je **Physician** lan /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) tha detached 9 Unknown 9 Unknown ate as been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 K No this certificate 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification; s after dea...ral Director: Afr 1 Natural 5 Pending Injury 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signaruje and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VALDORT, MO 20603 WATTAKEN MV 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 07 2007 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 11:30 am David laylor 31 2007 JUK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Johns Hopkins Bayview Medical Genter Bathmore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**№** M 2□ F Months Days Hours Min Director 111-54-3974 Sept. 7.1962 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Briarwood Road Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: Completed by 3 ☐ Widowed 4 ♥ Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Industry Deck Hand 9 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be John E. Taylor Dorothy L. Wilmouth 2 traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr 102 Briarwood Road Mr. John E. Taylor (Father) Dundalk, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ₩₩Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 8/4/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 unt. G ones Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Asphyua

Due to or as consequence of): /Medical Examiner Choking Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last MEDICAL EXAMINER Due to (or as a consequence of): ner that the death certificate be executed Exami ON APPROVED BY and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the CERTIF attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9☐Unknown 9 Unknown by signed t I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has performed? 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∭(Yes <del>2∭ No</del> 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? or Attending 5 ☐ Pending investigation 3:27 P 1 Natural within 24 hours are: ....
To the Funeral Director: Afr 5 Pending investigation of 1.28 - 2001 3:27 PM 1 Yes 2 No Subject ckcked on food ho determined building, etc. (Specify)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of a large and due to the cause (s) 2 Accident 3 ☐ Suicide 4 Homicide Hospitai 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier R25-000 31, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hicks 4940 Zastra trenve Bathmore, Medical Doctor MD Ashleigh 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 7 2007 Registrar

		For State Registrar	State of Marylar		artment of r <i>tificate o</i>				ene g. No. 🤉 🗎 🗎	7 00057
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last)  Lawrence Herman	Tormollen					2. Date of Death Month UGUST	6 <sup>Day</sup> 200 <sup>Y</sup> 7	3. Time of Death 12:26 A M
Examine		4a. Facility Name (If not institution, give str Gilchrist Center	of Death		4c. County of D	Baltimore				
Funeral Director		5. Social Security Number 6. Sex 113.1	7. Age (In yrs. 91	<i>last birthday)</i> Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day, 1/05/19	9. F 915	Birthplace (State or Foreign Country) Maryland
show sd at	ŗ	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltin		ty, Town or Lo	cation Parkvil	1e				10d. Inside City Limits 1 ☐ Yes 2 📉 No
death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 1334 Kenton Road			10f. Zip Code	21234		10	g. Citizen of What	Country?
or Ite		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	. Was Decedent Ever in U Armed Forces? 1 ∐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas Decedent of the Mas D			cify Yes or No- lican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
Hygiene. ther than "natur ent, the Medical	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give life.	dent's Usual Occ kind of work dor DO NOT use reti mator	cupation ne during mos ired)	st of workin	9	ome Furn	·
Mental Hy arked othe atlc event,	To Be (	17. Father's Name (First, Middle, Last)  Edward Tormollen					Kath	erine	Jacobs	
salth and Men n 27 Is marke er traumatic		19a. Informant's Name/Relationship (Type Rochelle Tormollen			ng Address (Stre I Kenton		er or Rural Par	Route Number,	MD 21234	, Zip Code) L
Department of Hee Important: If item any injury or othe once.		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	Ctata	cemetery, crei	sition (Name of matory or other p 11 Memor	rial (	D8/10,	/2007   1		ver, Maryland
Departme Importan any injur once.		21. Signature / Juneral Service Licenses	nes A		Leonard	J. Ruc	ćk, I	nc. Bal		d Road Maryland 2121
hysician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to or as a consec	te quence of):	er the mode of c	lying, such as	s cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
hysicia the bur	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							
attending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:. If yes, outcome pf pregn 1□Live birth 2□Feta 4□Pregnant at time of α 9□Unknown	al death 3 [	]Ectopic pregna ] Other <i>(specify)</i>				23d. Date of Month	delivery Day Year
n signed by the a	þ	Part II. Other significant conditions contr	buting to death but not res	sulting in the u	nderlying cause	given in Part	l.	23e. Did tob		e to the cause of death?  Probably 4 Unknown
this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Completed							24a. Was an autopsy perform	v prior	e autopsy findings available to completion of cause of '?'
this certificate al director, pag	To Be	To Ze No		ER/Outpatier	" OLI BOX	other: 4□N	ursing Hom		nce 6 Other (S	epecify) Hospice
aner death. <b>Director:</b> After thi	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At h building, etc. (Speci	28b. Time o Injury ome, farm, str	M 1	☐ Yes 2☐	No		w injury occurred reet and Number or , State)	Rural Route Number,
	Medical Co	29a. Certifier (Check only one)  1 ✓ certifying Physic 2 ☐ Medical Examine	cian: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the	e time, date a ny opinion, de	nd place, a ath occurre	nd due to the ca	ause(s) and manner ate and place, and	as stated. due to the cause(s)
To the compl	Me	29b. Signature and title of certifier	, Aly	, und	29c. Lice	ense number	5	29	August	onth, Day, Year)
2		30. Name and address of person who com	pleted cause of death (Iter	т 23a) (Туре, Е 70		Chen	les .	St. Bo	elts.m	121205
Stat	te	31. Date filed (Month, Day, Year)	3. Registrar's Sign	ature La	dis				_	

Registrar DHMH 17 Rev 1/2001

State

12+1

EDGEWOOD, MD.

21040

BUSINESS CENTER WAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

KMAN

STANLEY M. 31. Date filed (Month, Day, Year) 1308

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19b, perINF, G870,8710/07 WS
State of Maryland's Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		rtificate of			Jiene leg. No. 🥠 🦳 🎁	7 2505
ps:	Physicia	an	1. Decedent's Name (First, Middle, Las Camilla W					2. Date of Dea Month August	3 <sup>ay</sup> 2007	3. Time of Death 7:38 р м
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			r Location of Death		4c. County of E	
b	Funeral	ayr —	306 Gailridge  5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Director		312-18-6918 <sup>1</sup>	□M 2X□F 85	Yrs.	Months Days	Hours Min.	June 24	1, 1922	Indiana
	aryland show d at	Ļ	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	the Ma 28a-f s notified	recto	Md. Baltimo	ore	Timoniu	10f. Zip Code			10g. Citizen of Wha	1 ☐ Yes 2 X No t Country?
	23a or ust be	Funeral Director	306 Gailridge Ro				21093			JSA
0000	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ð	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
2	n 72 ho " <b>natur</b> edical	leted	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	king	16b. Kind of Busine	ess/Industry
717	ed withi /giene. er than t, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +1	Homen				0wn	Home
2	d be filk ental Hy ked oth c eveni	To Be	17. Father's Name ( <i>First, Middle, Last,</i> <b>Curtis Woodwo</b> l				18. Mother's Nam Cather		Maiden Surname) newitzer	
, Mary	and 2 shoul alth and M 27 is marl er traumati	-	19a. Informant's Name/Relationship (	ner/ Son	7623	l <del>ZoeT</del> Dr	. Baltimo	ral Route Numbe	r, City or Town, Sta 21237	te, Zip Code)
Dallinore	permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval from State	11top S	sition (Name of matory or other place Service C	o. 8-7-		Towson,	
סם	permit. Depart Import any Inj		21. Signature of Funeral Service Lider	nsee	22	2. Name and Addre Ruck T	ss of Facility OWSON Fur ork Rd	neral Ho	me, INc. Md. 21204	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deaf one cause on each line.	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aSTO	SREN juence of):	's DISC	EASE			
	Examiner	_	Sequentially list conditions,	a. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a co	VARY	FIBRO	2512			
	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.	luerice oi).					
0000	icate be executed physician and s the burial-transit	al Exa	resulting in death) Last	Due to (or as a consec	juence of):					
0	± 0 €	Medical	IF FEMALE:	d						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of of 9 ☐ Unknown	aldeath 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
COLUS, T	equires that en signed b ould be deta	ò	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		te to the cause of death?  Probably 4 Unknown
ב	: The law ricate has be	Completed						24a. Was a autop perfor 1∐ Yes	med2   deal	e autopsy findings available r to completion of cause of th? Yes 2 □ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ysiciar is certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatier	nt 3 DOA Oth	or	th <i>(Check only or</i> ome 5 ☑ Resid	ne) ence 6 □Other (	Specify)
5	iding Ph th. : After th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor			ow injury occurred	
	al or Atten s after deal Il Director d in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 200 Place of injuny - At h	l ome, farm, str fy)			28f. Location (S City or Tow	treet and Number o	r Rural Route Number,
	ne Hospita n 24 hours ne Funera pletely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examinated and planner stated.	ation and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place, and	due to the cause(s)
	Vithi To the	Ž	29b. Signature and title of certifier	A Join		29c. Licens	se number	2	29d. Date signed (N	fonth, Day, Year)
	6		30. Name and address of person who	completed cause of death (Iter  MD 54 5c  32. Restar's Signary  2007	n 23a) (Type,	Print)	- 000		08106	1200 /
1	)		MARK SABA 31. Date filed (Month, Day, Year)	mD 5450	CIT A	DAM ROY	to cock	Cojsvill	E MD	21030
	Sta Registr		AUG 0 7	2007 Mayers	J. A.	porte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 602 AM TUCKER August 2 7007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Hospital Johns Hopkins If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min, 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days 249.54.2970 1 M 2 □ F South CARDINA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at NIA BALTIMORE 1 Ves 2 No 140 Director 10e. Street and Number 30 is Idin ST. 10f. Zip Code 10g. Citizen of What Country? 21224 45 Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural", or 1 □ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) HEATING /AIR College (1-4or 5+) NLUMMER permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic event the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be GEORGE TUCKER BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 BOWLEIN ST. BALTIMORE, MD 21224 MARY TUCKER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/8/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMOREMA METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) Phillips FUNERAL NOTHER 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1721-27 N. MONINE ST. BACTIMUSE, ND ZIZIT necto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meumonia week /Medical Due to (or as a consequence of): Examiner Le months Cancer Luna Sequentially list conditions, if any set in the cause in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a con-equence of Examiner certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed' certificate 2□No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Doctor August 2 2007 RES-BOD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, AUG

Amy DeZern, The Johns Hodius Avoital 600 North Wolfe Street, Baitmore, Maryland 21287
31. Date filed (Month, Day, Year) 32 Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Yea **Physician** Vertaillie 2007 David 22:53 M Jason 07 29 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UMMC Baltimore, MO Baltirore City Shock Trauma Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F 18 10-17-1988 Maryland Director 216-29-4703 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland fleath and Mental Hygiene.

72 Is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Harford Bel Air 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2839 Forge Hill Rd 21015 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12+ Electrical Apprentice F. Lamar Mergler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Verfaillie Sharon Breedlove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai once. 2839 Forge Hill Rd Bel Air, MD 21015 Sharon Verfaillie (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-03-2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final anoxia /hernia tion **Physician** Cerebral disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner Head Injury 19 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and s the burial-transit Motor Vehicle resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2□No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation a er death. I Director: Al 0400 A M 1 🗌 Yes 2 **☑** No 7129107 MVC 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 3040 Sandy Hook Rd., Durlington, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

6-1991

31. Date filed (Month, Day, Year)

18237

MO Division of Surgicul Co. Heal Care, 22 South Greene ST, Ste T3R32

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month KEN 1AMS :45 AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SECOURS OSPITAL BALTIMORE BON N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1-≦ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 218-48-2788 Maryland Director JAN 11 Usual Residence of Decedent filed withIn 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Exeminar inust be notified at 1 XYes 2 No N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ᡖ 2428 Edmondson Avenue 21223 USA Funera 12. Was Decedent Ever in U.S. Amed Forces? 1 ∑Yes 2 □ No IfYes, Give Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Correctional Officer State of Maryland 12 permi. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>once</u>. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry L. Williams Cassie Α. McKnight ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harry L. Williams, Jr. - brother 134 Palormo Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/7/2007 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, 21. Signature of Funeral Service Licensee H <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams Huu 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Lue to (or as a consequence of): CARDIOVASCULAR DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine GE attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the 9 Unknown as been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No pag this certificate 1 ☐ Yes or Attending Physician: : After this certifical funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 ☑ Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel within 24 hours 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 00303 55 <0/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS M-N <05 31. Date filed (Month, Day, Year) State AUG 0 7 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Kevin John Walsh 31 2007 06:1AD 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 12/17/1963 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Maryland 1 MM 2□F 43 213-84-2759 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits MD Baltimore 1 Yes 2 No 10f. Zip Code 21214 10g. Citizen of What Country? 10e. Street and Number 2111 Westfield Avenue 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Specify: white 1 □ Never Married 2 □ Married 1□Yes 2KNo Specify: 3 ☐ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Chef (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 17 Father's Name *(First\_Middle\_Last)* Bernard J. Walsh 18. Mother's Name (First, Middle, Maiden Surname) Joan F. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 N. Center St. Fredericksburg, PA 17026 Kyle Walsh/brother 20a. Method of Disposition 1 ☐ Burial 2 Decremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/3/2007 Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3717 Green Fastures Dr. 212 36 21. Signature of Funeral Septice Licenses Cremation & Fun. Alternatives Towson, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANOXIC ENCEPHALOPATHY resulting in death) Due to (or as a consequence of): CARDIO RESPIRATORY Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). **EMPHYSEMA** Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. The marked other than "natural", or Items 23 ants. If item 27 is marked other than "natural", or thems 23 ury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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the Maryland

with

attending physician and for use as the burial-tran signed by the a has certificate has irector, page 2

Physician/Medical To Be Completed by

Exami Medical Certification:

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

29a. Certifier

(Check only onel

State Registrar

	STATUS P	OST BULL	ECTO	MY					-	1 ☐ Yes 2 [	□ No 3 □ Pro	bably	4 Unknow
-	RENAL IN	SUFFIENC	Y						-	24a. Was an autopsy performed? 1  Yes 2 No	death?	ompletio	on of cause of
25	5. Was case referre examiner? 1 ☐ Yes 2 🛣 N		Hospital	: 1 <b>∵</b> Inpatient 2□	] ER/Outpatient	3 🗆	045			Check only one)	3 □Other (Spec	eify)	
27	<ul> <li>Manner of Death</li> <li>1 ☑ Natural</li> <li>2 ☐ Accident</li> </ul>	5 Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury a Work? 1 ☐ Ye	it s 2 □ No	28	d. Describe how injury	y occurred		
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28	f. Location (Street and City or Town, State)	d Number or Ru )	ral Rout	te Number,				

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier civil Neun

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINTHICUM. RICHARD L M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

AUG 0 7 2007

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August <sup>□</sup>4 2007 **Physician** 5:54 AM Mee Kuen Wong /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 128 Virginia Avenue Baltimore Essex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day Year) Jan . 12, 1929 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 220-68-1134 Months Chintry) 78 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Essex 1 ☐Yes ŽÍ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 128 Virginia Avenue 21221 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 To Yes 1 To Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 No Specify Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Restaurant 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chung Cheung Hom Ngan-Ai Wan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Wong /daughter 13727 Bonilla Lane Houston Texas 77083 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Oaks 8/8/07 Houston Texas 4 ☐ Donation / 5 ☐ Other (Specify) Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 00 BYTHAT /Medical Due to (or as a consequence of): **Examiner** na Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) a∏l Jnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural"; or Items 23a or 28a-f show unt. Pfile the 17 is marked other than "natural"; or Items 25a be notifitied at uny or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Certification: To

Medical

27. Manper of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Ave., Batto, MO 2/22/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Loh 31. Date filed (Month, Day, Year Year)

5 ☐ Pending investigation

6 ☐ Could not be

32. Régistrar's Signature

28a. Date of Injury (Month, Day Year)

Registrar

Provide the County of Death Survey (First Middle Late)    1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (First Middle Late)   1. Decedent's Name (				1 For	State of Maryland					/	17	25255
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07-05518

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Undrea R. Williams 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 18, 2007 1645 hrs Madical Examiner IAMS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 6701 Brentwood Avenue Dundalk 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours Director Country) Mi 129 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 "natural", or items 23a or 28a-f show Ex miner must be notified at once. mil Timore Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Numbe entwood 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married Yes Yes 2 No specify: Pages 1 and 2 should be filed within 72 hours after tent of Realth and Mental Hygiene. ant: If item 27 is marked other than "natural", a If Yes, Give Year Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print ) ent of Health and nt: If item 27 is other traumat 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State 1 Burial 2 ARME tant: Other Specify: ò 22. Name and Address of Facility 21. Signature of Funeral Service Licenses TE (-UNCAR) m0,2/2/3 DATT, MORE 5 AROI 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. 'Medical Death Mixed drug (morphine and cocaine) intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical tending physician a X UNPENDED AMENDED 27, 28a-f. perME, g870, 8/8/07 TT Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Day Fetal death Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown 9 Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. <u></u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Δ. Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? 1 🗸 Yes Yes 2 No this certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 V Yes ٩ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Medical Certification: Natural Yes 2 X No within 24 hours after death.

To the Funeral Director: Fnd 7/18/2007 Fnd 4:36 pm in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 6 X Could not be (Specify) Found: residence 6701 determined Brentwood Ave. Dundalk, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of July 19, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Susan Hogan MD. 31. Date filed (Month, Day, Year)

State Registrar

soistrar's Signature

2007

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#### 07-05569 Gle

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

enn Wilson		For State Certi	ficate of Death	Reg. No.	
Physiciar	_	gistrar Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day	3. Time of Death
edical Examin		Glenn Wilson a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	July 19, 2007	c. County of Death
	4	A. Facility Name (if not institution, give street and number)  Harbor Hospital	Baltimore		
Funeral	5	Social Security Numbetink 6. Sex 7. Age (In yrs. las		-	I/DD/YYYY) 9. Birthplace (State or unk
Director		1XM 2F 48	Yrs. Months Days Hours Mir	June 13,	1959 Country)
	_	Isual Residence of Decedent	own or Location		10d. Inside City Limits
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faryland	힑	Oe. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
he Mar or 28	Director	1032 Light Street	21230		USA
with the ns 23a		1. Marital Status unk 12. Was Decedent Ever in U.S		Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
death or iten	5)	1 Never Married 2 Married 1 Yes 2 No			Specify:
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136 thin 72 re. than	nple nple	unk unk			
5-00 led witl Hygien I other the Me		17. Father's Name (First, Middle, Last)	unk 18.Mother's Nar	me (First, Middle, Maide	en Surname) unk
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shu numatic eveut, the Medical Examiner must be notified at once	e le	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number o	or Rural Route Number,	City or Town, State, Zip Code)
MD 2 d 2 shoul lith and IN m 27 is m	ř	O.C.M.E.		ltimore, M	0 21201
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Baltimore, permit. Pages I a Department of He Important: If ite	ı	2 atur uneral i Licen e e irector	22. Name and Address of Facility State Anatomy Boar	rd 655 W. H	Baltimore Street
	- 1	23a. Phi I. Enter the dise se, complicitly insight caused the death.	—— [Raltimore, MD 212	201	
Physician ledical		fail e. List only one cause on each line.	osclerotic cardiovascular c		Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive autre	f):		
		Sequentially list conditions, b	2		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause C.	t):		
_ ii	xam	(Disease or injury that initiated events resulting in death) Last	f):		
vecuted n and - transit	a E	d.			
30, te be exe ysician	edic	IF FEMALE:  d.  AMENDED  #23, PII, 27, perl  23c. If yes, outcome of preg	ME,g870, 8/9/07 TT		23d. Date of delivery
Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be executed reath. The factor and provided the second of the physician and birector. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transitions.	M/ne	23b. Was decedent pregnant in the	2 Fetal death 3 Ectopic pre	gnancy	Month Day Year
ox 6 ath cer attend	Physician/N	1 Yes 2 No 9 Unknown g Unknown	eath 5 Other (Specify)		
D. B. the de by the Iched f	Ph	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.		cco use contribute to the cause of death?
P.C es that igned l	ĝ	Chronic cocaine use		1 Yes	2 No 3 Probably 4 V Unknown
rds, require been s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
e law te has ge 2 sl	dw			performe	
II Re		25. Was case referred to medical	26.Place of Death (Che		
Vita hysicia this ce	To Be	examiner?  1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2	2.000.	ursing Home 5 Re 28d. Describe hov	sidence 6 Other:
I Of ing P! After funera		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No		vinjury occurred
Sior Attend death. ctor:	catic	T Change	nome, farm, street, factory, office building, etc.		eet and Number or Rural Route Number, City
Divis al or A s after al Dire	Certification:	Suicide 6 Could not be determined (Specify)	ionio, ionio, and any income	or Town, Stat	e)
Division of Vital I the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifupletely filled in by the funeral director.	Ce	29a. Certifier	dge, death occurred at the time, date and place,	and due to the cause(s	s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurr	red at the time, date an	d place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
To wit	Re	29b. Signature and title of certifier	29c. License number O.C.M.E.	ì	July 21, 2007
		Potruia Grania-Poll	er no		July 21, 2007
9		30. Name and address of person who completed cause of death (Ite Patricia Aronica-Pollak MD. Assistant Medical	<sup>m 23a)</sup> Examiner 111 Penn Street, Baltir	more, MD 21201	
	tata	200 State of the Art 2007 32 Registrar's Signa	<i>B</i>		
S Regis	tate	AUG'U" LOUI JUBBLE &	- Marie		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DENVA, WARNER 07: IDAM 07 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100M 2□ F Days Months Hours Director 0 July 17, 2007 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examples must be notified at 10d. Inside City Limits 1√ Yes 2 No Director MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 death v 46 Janper Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Denva Warner Darnell Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Hospital 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 □ Donation 5 K Other (Specify) in state 21. Signature & Eueral S. violed icens Wade, State Anatomy Board 655 W. Baltimore Street Wirkctor Les Baltimore, MD 21201 23a. Part Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician HYPER KALEMIA 5hrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner adays CONSEQUENCE OF EXTREME PREMATURITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen SeDSI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy intraventricular Hemory 2 No 1 Yes 25. Was case referred to medical examiner? Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 Hatural 5 Pending death. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) nee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore MD 22 SOL RmN5W68 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend item: 25 Maryan & Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 08:40 AM 200 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** niversit Maryland Medical Center Baltimore 0 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 👿 F 213-34-8624 69 Director July 22, 1938 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notifled at MD 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Pages 1 and 2 should be filed within 72 hours after death with Items 23a 1926 Altaview Road 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No by Specify. If Yes, Give Year or Dates: Specify: white 3 XWidowed 4 ☐ Divorced 'natural", Completed d other than "natu event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Iem 27 Is marked other than transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilbert Earl Roberts Ella Marguerite Holliday 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Sarah Bowling/daughter 9775 Sporting Clay Place LaPlata, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Sept 22. Name and Address of Facility S. Wade, Mirector State Anatomy Board 655 W. Baltimore Street 2222 Baltimore, MĎ 21201 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Alcoholic Cirrhosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? /es 2 1 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this id in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) P19729 MB 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, MD Hepp MD 22 21201 South Greene

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2007

3. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>007</u> Pearl Louise Wittmyer August 1, 8:45 A. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A 1300 Berry Street Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | Feb. 29, Year 921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Months Mary I'and 1 □ M 2 🗓 F 86 213-18-7470 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 1300 Berry Street 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🍇 No White Specify Specify: ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Blanche Mann Alvie May Keeney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Lou Vancouyghen Daughter 1300 Berry Street Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Finksburg Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/3/2007 Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J Fineral Service Licenses 22. Burgee Henses Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cirdlac acchythmia IMMCAIL. disease or condition resulting in death) Due to (or as a consequence of): ardlonyopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month

**Physician** /Medical **Examiner** 

Department of Important: If its any injury or o once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

traumatic event, the Medical

d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "ne

Pages 1 and 2 s ment of Health an ant: If item 27 Is I

72 hours after

Saltimore, Maryland 21215-0036

Director

þ

Completed

Be

as the burial-tran attending physician use a for cate has been signed by the a page 2 should be detached this funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Certification: To Be Completed by

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Yes 2 No

4☐Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 24a. Was an autopsy performed? Yes 2/\ No

26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 27. Manner of Death

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only one) 29b. Signature and title of certifier

31. Date filed (Mog

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29d. Date signed (Month, Day, Year)

Men openthin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3414 St Paul Street Buly Rosenthal MD

State Registrar 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

X.	1	For State Registrar  1. Decedent's Name (First, Middle, La	st)	Ce	rtificate of	Death	2. Date of De	Reg. No.	017	3. Tîme ot	27 Death
Physicia		Charlo			Wareh	ime	Month August	2, Day 200	7 Year	10:3	4 ам
/Medica		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Deat			nty of Death		
		Carroll Hospital	Center		Westmin				roll		
Funeral Director			7. Age (I. M 2 XF 84	n yrs. last birthday, Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da pril 19	th <i>Year)</i> 1923	9. Birth Cou Cana	olace (State ontry) 1a	or Foreig
Hygiene. ther than "natural" or items 23a or 28a-f show ant, the Medical Examiner must be notified at	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation					10d. Inside C	ity Limit
:8a-f sho	ector	Maryland Carroll		Sykesvil				10g. Citizen	of Milest Cou	1 □Yes	<b>¾</b> □N
23a or 2 ust be n	Funeral Director	10e. Street and Number 7200 Third Avenue	0-303		10f. Zip Code 21784		Į	Jnited		•	meri
xan .	<u>م</u>	11. Marital Status 1	12. Was Decedent Eve Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗓 No		Specity Yes or Norto Rican, etc.)	E	Race - Ameri Black, White, ecify: Wh	etc.	
n "natur Aedical E	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)  College (1-4or 5+)	i (Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of wa	orking	16b. Kind o	f Business/Ir	dustry	
r tha	E	Elementary/Secondary (0-12) 12th	College (1-40f 5+)	Home	maker			own ł	ome		
othe /ent,	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's Na	me (First, Middle	, Maiden Suri	name)		
rked tic e	2	William Oscar Roe	elecke			Ruth Ca	rolyn Tl	nomas			
Ith and Mental Hygiene. 27 Is marked other than r traumatic event, the M		19a. Informant's Name/Relationship (			ing Address (Street		C1	er, City or To		,	
t realth	Ì	20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla	ice)	Date	20c. Location	on - City or T	own, State	
Department of Health Important: If Item 27 any injury or other tronce.		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemovai from State	Metro Cr	ematory A	ugust 3,					
Department of the limbortant: If ite any injury or of once.		21. Signature of Funeral Service Lice	Mo1234	I .	2. Name and Addre						
25		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not er	ter the mode of dyi	ng, such as cardia	c or respiratory a	arrest,		Approxima Interval Be	te
ysician		Immediate Cause (Final	one cause on each line.	ACHI	)					Onset and	Death
ledical		disease or condition resulting in death)	a Due to (or as a c	onsequence of):						1371	279/6
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ig physician and as the burial-transit	edical Examiner	resulting in death, East	Due to (or as a c	onsequence or):							
the attending	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	гу		23d.	Date of delive Month		Year
signed by the a	by Ph	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause gi	ven in Part I.		tobacco use o			
should t	ed						1 -	Yes 20 N	o 3∏Pro	bably 4 □	Unkno
ge 2 sh	Completed						perf	opsy ormed?	death?	opsy findings ompletion of o	availa cause o
ificate or, pa		25. Was case referred to medical				26 Place of De	1  Yes eath (Check only	2 No	1 ☐ Yes	2□ No	
s cert	o Be	examiner? 1 Yes 2 No	Hospital: Inpatient	2 ER/Outpatie	ent 3 DOA Ot	har:	Home 5□Res		Other (Spec	ifv)	
er this	n: To	27. Manner of Death	28a. Date of Injury	28b. Time			28d. Describe		<u></u>	-97	
ath. r: Aff	igi	1 Natural 5 Pending 2 Accident investigation	<i>(Month, Day Y</i> n	<i>ear)</i> Injury	I .	Yes 2 No					
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, s Specify)	treet, factory, office		28f. Location City or To	(Street and No own, State)	umber or Ru	ral Route Nur	nber,
within 24 hours a  To the Funeral I  completely filled	lical C	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of i miner: On the basis of e and manner state	camination and/or	th occurred at the to	ime, date and place opinion, death oc	ce, and due to the curred at the time	e cause(s) and e, date and pla	d manner as ace, and due	stated. to the cause(	(s)
ithin of the omple	Med	29b. Signature and title of contifier			29c. Licen	se number		29d. Date si	gned (Month	, Day, Year)	
3 F 8		> The CI	vale p	7. D.		5955		8/	3/20	7	
*		30. Name and address of person who	·	th (Item 23a) (Type	Print)  0. 700A	and-	01 1.2	ECT are	720	241) 2	115
		CounsHANT		not m-	D. 100A	ruse	in we	~1 /B/ N.)	19/	mu di	1/ )
01-	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 95979 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST Day Z **Physician** 2887 08:01F M John Allen Walck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Saint Joseph Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Director 216-12-2293 88 Sept. 11,1918 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified. 1 ☐ Yes 2 X No Director Carney Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 Funeral 21234 7 Joni Ct. U. S. A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married P. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Conductor Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H item 27 Is marked oth r other traumatic even Be John Walck Pauline DePue P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Roth (Daughter) 7 Joni Ct., Carney, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 08/06/2007 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licen 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC DYSRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Il Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. To the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 M.D. 7601 OSLER DRIVE TOWSON. MARYLAND 21204 KHOSROW TABASSI. 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 3, 2007 **Physician** 7:30 A M Helen E. Wells /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1 Smeton Place Apt. 507 Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/04/1931 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F Iowa 343-24-3150 75 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 28a-f show "natural", or items 23a or 28a-f shov sdical Examiner must be notifled at 1 ☐ Yes 2 No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 1 Smeton Place Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Sandager Emmitt Lahiff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Burnside Road, Hampstead, MD. Donald Wells (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hillton Svc. Corp. 08/08/2007 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signavire of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending PhysIclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Prineral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Ticcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo Osler Drive, Towson, Maryland 21204 Year) egistrar's Signature State AUG 0 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Willis **Physician** Vicev Ju1y 31 2007 10:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Nursing Home Glen Burnie Anne Arundel County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 X F Yrs Director 96 12, 1910 Virginia 214-22-0509 Usual Residence of Dece Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 3rd Street U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 □ Divorced Completed by White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Floyd Andv Dee1 Martha Clevenger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 3rd. Street Baltimore, Maryland 21225 Josephine W. Teague (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 08/04/07 Brooklyn Park Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 East Patapsco Avenue Baltimore Maryland 21225 21. Signature of Fuperal Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician uuc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading Lamma lich cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. fical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 29b. Signature and title of cartifier 29c. License number son who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

COCI

32. Registrar's Signature

Year)

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1 - For State Registrar	
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Certificate of Death

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Physician
/Medical
Examiner
 Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

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Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death or	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attend	completely filled in by the funeral director, page 2 should be detached for us
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		23a. Part1. Enter	e disease, or con	nplications that cause one cause on each	d the death	. Do not ente	er the mode of d	ying, such	as cardiac o	or respiratory a	rrest,			Approximate Interval Between	_
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Ì	ian	23b. Was decedent in the past 12			2 Fetal	death 3	Ectopic pregnar	псу				23d. Da	te of deli nth	very Day Year	
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	h h	Part II. Other signif	ficant conditions	contributing to death I	out not resu	Iting in the ur	derlying cause o	given in Par	rt I.	23e. Did t	obacco	use cont	ribute to	the cause of death?	
Ì	Completed by	F	allie	tota	rue					10	Yes 2	2□ No	3∏ Pr	obably 4 donknown	
	Sete									24a. Was		24b.	Were au	topsy findings available ompletion of cause of	
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	P B	examiner? 1 ☐ Yes 2 🗹	No	Hospital:	ient 2 🗆 I	ER/Outpatien	3 DOA C	an #	/	me 5 Resi		6 □Oth	er (Spec	eify)	_
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	atio	2 ☐ Accident	5 ☐ Pending investigation	n	, ,	,,		Yes 2	□No						
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	-	30. Name and addr	ress of person who	completed cause of	death (Item	23a) (Type I	Print)		12-		0	<u></u>			_
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical AUG.3,2007 11:20P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RICHIE HOSPICE BALTIMORE if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2□F 69 Director 212 34 1919 NOV.6,1937 DELAWARE Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD. N/A Director BALTIMORE 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 3009 wayne 21207 USA ral", or Items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **2TH** STORE CLERK17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked other traumatic ev JOSEPH WILSON MILDRED CANNON ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARNELL J.WILSON SR. (son) 3009 Wayne Ave. BALTO, MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Sec. 12) 20c. Location - City or Town, State Important: If it any injury or o WOODLAWN CEM. AUG.11,2007 BALTO.CO.MD. Signature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME 1412 Ε PRESTON ST. BALTO MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner - a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as t attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 1 ☐ Yes 2 ☐ No 2 1 No or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sther (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Signature and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) D26880 Name and address of person who completed cause of death (Item 23a) (Type, Print) place Balt. Tul. 21 Armorn 31. Date filed (Month, Day, Year) Registrar's Signature 32 State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6, 2007 **Physician** 3:15 Aug. Gino Franco Luigi Zarbin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore, Baltimore 6637 Loch Raven Blvd. MD Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

Italy 8. Date of Birth (Month, Day, Year) June 27, 1924 If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number **Funeral** Months 216-40-5232 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland ntal Hygiene. 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, tr∗ Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Baltimore, MD Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21239 6637 Loch Raven Blvd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Specify: White 1 □ Never Married 2X Married 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pediatrics Doctor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giovanna Bandel Attilio Zarbin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Adriana Zarbin/Wife permit. Pages 1 and 2 sh Dupartment of Health and Important: If item 27 is many Injury or other traum 6637 Loch Raven Blvd., Baltimore, MD 20b. Place of Disposition (Name of Dulaney Valley Walley Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 8/10/2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Rd., Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. netastatic Immediate Cause (Final disease or condition resulting in death) Retric cancer ULANS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 ☐ Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown non-holophins Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No abrillation 24a. Was an atrial autopsy performed? (es 2 No page 2 s 1□ Yes After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 27. Mannel of Death Certification: 1 Naturai 5 Pending investigation 1 Yes 2 No death. 2 Accident after death. filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.0. Division or Vital Records,

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Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral I

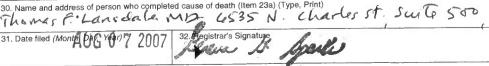
State

31. Date filed (Month Dag Yar) 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifier



Registrar

29c. License number

D43936

29d. Date signed (Month, Day, Year)

Bactimore MD 21204

07-05829 John Victor Adair

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ne	2007	25278
Reg. No.		

0 (10.0. / 100	1- For State Certificate of Death Registrar	Reg. No.	141
Physician/	Decedent's Name (First, Middle, Last)  2.	Date of Death Month Day Year 0730 hrs	
Medical Examiner	001111	Month Day Year 0730 hrs	,
1	4a. Facility Name (if not institution, give street and number)  7003 Prout Drive  4b. City, Town, or Location of Death Friendship	Anne Arundel	
Funeral Director	Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Foreign	
Bilector	212–54–2319 1 X M 2 F 73 Yrs. Usual Residence of Decedent	10-21-1933 Country) Cana	da
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside C	
Maryland 28a-f show d at once. ector	MD Anne Arundel Friendship	1 Yes	2 X No
the Maryland to 28a-f shriffled at once	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
ith the Maryland 23a or 28a-f sho notified at once.	7003 Prout Road 20758	USA ify Yes or No- 14. Race - American Indian, Bla	ack
after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Neve: Married 2 X Married 2 X Married 2 12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specific Never Married Proces?)  14. Was Decedent of Hispanic Origin? (Specific Never Married Proces)	.,	ron,
fter de	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	specify: white	
	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired during most of working life. DO NOT use retired		
16 n 72 h nan "n ical E	Elementary/Secondary (0-12) College (1-4 or 5+)  12 printer typographical		
5-0036 led within 72 hours lygiene. other than "natur the Medical Exam Completed 1		First, Middle, Maiden Surname)	
21215-0036 Jude be filed within 7 I mental Hygiene. I marked other than it event, the Medica To Be Comple	James Currie Adair Christi		
	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Run	*	
Marth 2	Lorna D. Adair, spouse 7003 Prout Road, Frie	Date 20c. Location - City or Town, State	
Baltimore, Pormit. Pages 1 and Department of Healt Important: If item Injury or other trains	1 Burial 2 X Cremation 3 Removal from State crematory or other place)	02 07 Alexandria VA	
Baltimore permit. Pages I Department of Important: If injury or other	4 Donation 5 Other Specify: Metropolitan Crematory 08– 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rau	sch Funeral Home, P.A.	
Dept.	William R. Offin 8325 Mt. Harmony L	ane, Owings, MD 20736	9
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	Between C	Onset and
/Medical aminer	Immediate Cause (Final disease or condition resulting in death)  A Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):	Dea	atn
	Sequentially list conditions,  b.		
ner	if any, leading to immediate Due to (or as a consequence of):		
ted The linesit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
760, cate be executed physician and the burial - transit	d		
'60, ate be execu obysician and be burial - tra	UNPENDED AMENDED	23d. Date of delivery	
1876 rtificat ing phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		Year
). Box 687 the death certification by the attending ched for use as I Chacician!	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown		
D. B I the di	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of	death?
P.C.	Chronic Alcoholism	1 Yes 2 No 3 Probably 4	Jnknown
Records, I , The law requires ficate has been sig , page 2 should be		24a. Was an autopsy findings prior to completion of	
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f Vir	1 Ves 2 No line of Injury 28b Date of Injury 28b Time of Injury 28c Injury at Work? 2	Home 5 Residence 6 ✓ Other: Scene	
nding th. r: Aft	1 ✓ Natural 5 Pending (Month, Day, Year)  1 ✓ Yes 2 No		
/iSic r Atte her dea irector n by tf	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	28f. Location (Street and Number or Rural Route Nu or Town, State)	mber, City
Division of Vital Records, P.O. Box 68' spital or Attending Physician: The law requires that the death certifineral Director: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as Contributed by the Division: To Be Completed by Bytesician			
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death or the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit modical Certification: To Be Completed by Physician/Medical Exal		due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)	
To Cor	and manner stated.  29b Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Yea.	r)
	( ) a latern O.C.M.E.	July 31, 2007	
20	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	 )1	
Stat	10 1 1 (* 11 */ /1111 / 1224 a /b /APRICATA		
Registra	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa		

POLINARES

Months

BRUNSWICK

10f. Zip Code

CENTER

10c. City, Town or Location

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

BALTIMORE

Hours

2. Date of Death

8. Date of Birth (Month, Day, Year

OCT. 13,

Dav

1979

Year

N/A

10g. Citizen of What Country?

2007 4c. County of Death

Month

Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1X Yes 2 □ No

WEST VIRGINIA

20 PM

			1	Please	Type or Prii	IL III E	nac
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			for State Registrar				
			1. Decedent's Name	e (First, Middle, La	nst)		
	Physici /Medic			HOLE		A	20
2	Examin	er	4a. Facility Name (f	f not institution, giv	ve street and number)		CE
			JOHNS H	OPKINS C	BAYVIEWV	NEDU	CAL
	Funeral		5. Social Security N		_ 34	e (In yrs. i	last b
	Director		233-25-02	257	1□M 2XXF 2	27	
	D		Usual Residence of	Decedent			
	ylan ylan at		10a. State	10b. County		10c. City	y, Tov
	a-f sh iffled	ż	MD	FREDER	RICK		
	r 28	Director	10e. Street and Nur	mber		-	
	th with		727 BRUN	NSWICK ST	REET		
	dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S.
٥	after or It		1 ☐ Never Marr	ied 2 <b>□X</b> Married	1 ☐ Yes 2 💢 I	40	
3	Exal.	þ	3 Widowed	4 Divorced	Year or Dates:		
ņ	72 ho 'natur dical		(Spec		16		
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	i+)	CE
0	Hy othe	Be	17. Father's Name	(First, Middle, Las	t)		
lan	1 and 2 should be filed with Health and Mental Hygiene em 27 is marked other tha ther traumatic event, the N	To B	CHARLES	A. ROBER	RTSON		
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5	nd 2 alth a 27 is		CHARLES A	. ROBERTSON	N / FATHER		
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V			23a. Part1. Enter t	he disease, or con	nplications that caused	the death	n. Do
			Immediate Cause		one oude on each in		

Physician /Medical Examiner

physician and the burial-transi as P.O. Division or Vital Records, To the Hospital or Attending

21716 USA 27 BRUNSWICK STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 KMarried 1 ☐ Yes 2 ☐ XNo Specify: WHITE ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) mentary/Secondary (0-12) STATE OF MARYLAND CERTIFIED AND GERIATRICS NURSING 9 ther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLENE E. MARKLEY HARLES A. ROBERTSON Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 RYE DRIVE, HEDGESVILLE, WV 25427 IARLES A. ROBERTSON / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State RFD HEDGESVILLE, WV TOMAHAWK CEMETERY 31, 2007 □Donation 5 □ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821 327 W. KING ST., MARTINSBURG, WV 25402 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) I HERMAL INSURY 10 DAYS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation See. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 No 1 ☐ Yes within 24 hours after useum.
To the Funeral Director: / 2 Accident Propare EXPLOSION 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) See By CREEK CHANG, 2019 determined 4 ☐ Homicide CAMPGROUND BEDLELEY SPRINCE, WV 25427 1♥ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUCKSUN EASTERN AVENUE 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 7 2007 Registrar **ORIGINAL** 

Physician
/Medical
Examiner

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mertal Hyglene. Insert of Heath and Mertal Hyglene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or natural be notified at uny or other traumatic event, the Medical Examiner must be notified at Department of Important: If any injury or

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-tran signed by the at d be detached fo should ate has b page 2 s certificate

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica ours after death.

Neral Director: After this certific filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Thomas Alexander Adams 2:30 p. July 20, 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □X/1 2 □ F 216-56-7698 59 April 14,1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 1 ∐Yes 2 🙀 No Maryland Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5825 Empire Place 20658 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Craftsman Motel 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sidney Adams Mary Cecelia Simms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Adams Brother 9619 Heather Ct., Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <u>Ju</u>ly 26,2007 Charles Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Indian Head, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. M00668 23a. Part1. Enter the seas shock, or heart f illure , or complications that caused the death. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 Hospital: Other: 4 Nursing Home No ၉ Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sames Catevenis M.D., 3001 Hospital Dr., Cheverly, Md. 20785 31. Date filed (Month State Registrar

			1 - State of Mary		artment of I		•	giene Reg. No.	north	25281
			Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
	Physici /Medic		AGNES ARLENE BRANUM				AUG.	1,2007	Year	7:40 P M
}	Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Deal	4c. County			
			1830 BUDDS FERRY PLACE			N HEAD	CHAR			
	Funeral Director		213-42-9958 <sup>1□M 2</sup> X <sup>F</sup>	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) 1943	9. Birthi Coul MD •	place (State or Foreign ntry)
	and		Usuel Residence of Decedent           10a. State         10b. County         10	c. City, Town or Lo	ocation					10d, Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmst be notified at	ρ̈́	MD. CHARLES	IN	DIAN HE	AD				1 □ YesX2 □ No
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cou	ntry?
	th with		1830 BUDDS FERRY PLACE		2	0640		U.S.A	٠.	
	ams BLE	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No	- 14. Rac	ce - Americ	can Indian,
36	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, Tra Medical Examinationst be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specif		VHITE
Ş	2 hours		15. Decedent's Education	16a. Dece	dent's Usual Occur	pation		16b. Kind of B	usiness/In	dustry
212	filed within 72 Hygiene. other than "nates ont, the Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	orking			,
2	giene gritha	Com	12th		WAITRES	S		RESTAU	JRAN7	r's
Maryland 21215-0036	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)				me (First, Middle,		ne)	
<u>\S</u>		2	UNKNOWN				MA PACK			
Na Na	01 62 69 67		19a. Informant's Name/Relationship (Type, Print)  CHARLES L. BRANUM-SPOU		ng Address (Street BUDDS ]					
	s 1 and 2 if Health item 27 i			20b. Place of Dispo	osition (Name of	1	Date	20c. Lo206		
<u>و</u>	Pages nent of int: If it		1 ☐ Burial 2 ☐ €remation 3 ☐ Removal from State	cemetery, cre	matory or other pla		3 07 7	LEX.,V	2000	.,
aitimore,			21. Signature of Euneral Service Licensee MOO47	2 2	2. Name and Addre	ss of Facility				
ñ	permit. Depertr importa any inju		m/ 1/ (/1/2 B	1/	RAYMOND	FUNERA	L SERVI	CE,P.A	7 •	
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dying	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	onst	Com	cee				Onset and Death
	/Medical		resulting in death)  a. Due to (or as a co							
	Examiner	<b></b>	Sequentially list conditions, b.							
8	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):						
)	xecut and al-trar	Examiner	that initiated events c	onsequence of):						
8/60	cate be executed physician and the burial-transi	dicai E								
٥	tificat ig phy as the	ledio						- 10		
ROX	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2		Ectopic pregnanc	,		1	te of delive	•
o L	e dea the at ned fo	by Physician/Me	in the past 12 months?  1 □ Yes 2 0 No 4 □ Pregnant at tim 9 □ Unknown 9 □ Unknown		Other (specify)	'	-	Mic	onth	Day Year
J.	hat th	Phy	Part II. Other significent conditions contributing to death but n	ot resulting in the u	nderlying cause on	en in Part I	23a Did to	obacco use cont	tribute to t	he cause of death?
Hecords,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit				indonying dause gri	on in ruici.		res 2□No	3 Prot	6 0
ပ္ပ		Completed					24a. Was	an 24b.	Were auto	ppsy findings available impletion of cause of
	sician: The law certificate has b irector, page 2 s	Con						rme@	death?	2□ No
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?		Oth		ath (Check only o	ne)		
0		2	1 ☐ Yes 25 No 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		4 🗆 Nursing r		dence 6 Oth		5/)
	ling Afte fune	tion	1- Vatural 5 Pending 2 Accident investigation	nar) Injury	Wo	k? Yes 2 □ No	200. Describe t	low injury occur	160	
DIVISION	Attending r death. actor: Attention by the fune	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury	At home, larm, str	reet, lactory, office				er or Rura	al Route Number,
ā	s afte	Certification:	4 Homicide determined building, etc. 75	ресіту)			City or Tov	vn, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of manual control of the basis of examiner: On the basis of examiner stated	amination and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	719	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
			* Kent Ma	Un	0:	1835	52	81	HX	7
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) 1	01 1	. A .	1	~ ′	1 1
	8		21 Date filed (Menth Day York)	- 1) 9	6	Lega	, vo (	1 7	06	40,
*	Sta Registr		31. Date filed (Month, Day, Year)  AUG 0 7 2007	Signature And	ale)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Month 4:25 ам Rachael Elizabeth Buchanan 2007 July 31, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood of Williamsport Washington Williamsport 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🖺 F 213-16-0452 88 Sept. 15,1918 Georgia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13628 Royal Road 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene D. Miller Nellie Kate McCormick Miller ို 19a. Informant's Name/Refationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy E.Owens/Daughter 5108 New Kent Road, Wilmington, DE20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2007 Rest Haven Cemetery | Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Avenue, Hagerstown Md 21742 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimers years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in its later as each of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atherosclerotic Heart Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Mass- not biopsie Breast 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical **Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example.

ر To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division or Vital Records, P.O. Box 68760, after death.

I Director: Af
d in by the ful within 24 hours a

To the Funeral C

completely filled

Examiner Be Completed by Certification: To Medical

Physician/Medical

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Registrar

Cynthia Kuther-Sards, 00

29c. License number D47451

1 TYes

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 □ No

29d. Date signed (Month, Day, Year) July 31, 2007

Maryland

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16505 Virginia Avenue, Williamsport and Cynthia Kuther-Sands

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

5 Pending investigation

6 Could not be determined

			1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygiei		5.723
П	Physic	ian	Decedent's Name (First, Middle, Last			2. Date of Death Month	Day Yeer	3. Time of Death
A Park	/Medi	cal		JWA		107 16	2007	1708
	Examir	ner	4a. Facility Nama (If not institution, give Holy Cross	Hospital	4b. City, Town, or Location of Dec	ring	4c. County of Deeth	gomery
	Funeral Director		5. Social Security Number 6. S.  None 1  Usual Residence of Decedent	9x 7. Age (In yrs. last b	Yrs. If Under 1 Year If Under 24 Hr Months Days Hours Mir Days Hours Mir	n. (Month, Day, Ye.	ar) Coui	place (State or Foreigntry) Yyland
	ehow	2	10a. State 10b. County		wn or Location		1	10d. Inside City Limit
	r 28a-f	irecto	Mayland Vont	gomery Six	Verspring Vor. zip Code	10g.	Citizen of What Cour	17 Yes 2 N
	ath with	raiD	10 Redbud C	ourt Potoma	c 20854		USA	
20	be filed within 72 hours after death with the Maryland tal Hygiene. A contraint of other than "natural", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 ☐ Yes 2 (If No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify:	ean Indian, etc.
	72 hou	eted	15. Decedent's Ed (Specify only highest gra-	ucation 16a	a. Decedent's Usual Occupation (Give kind of work done during most of w	orking 16b.	. Kind of Business/In	
9500-51212	filed within Hygiene. other then ent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		NOW	e
Š	should be filed within the Mental Hygiene. marked other than matic event, the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the	To Be	17. Father's Name (First, Middle, Last) SHAHZAD R	4FCQ	18. Mother's Na FAR	AH B	FJWA	+
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Dalti	permit. Pege Department o Important: If eny injury or once.		4 □Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen:	1. 1.03 4	22. me and A. Piss of Facility  Sex Vico (242	den Mus REGGY St	1. 1.	ranglan idge VA
F	hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death. Do ne cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
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	e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	Day Year
	5 g	by	Part II. Other significant conditions co	ntributing to death but not resulting i	in the underlying cause given in Part I.		o use contribute to th	ne cause of death?
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	certificate rector, pag	Bec	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	40 103 163	2,55,110
Ohvajojan	this al di	ို	1 ☐ Yes 2 ☑ No 27. Manner of Death	lospital: 1 Inpatient 2 ER/Ou	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Home 5 Residence		)
Lor Attending Physician:	death. ctor: After y the funer	cation	1 Natural 5 Pending 2 Accident investigation		Time of injury 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred	
	- # .E	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura. ite)	l Route Number,
Hospital	within 24 hours after deat  To the Funeral Director;  completely lilled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place id/or investigation, in my opinion, death occu	e, and due to the cause( urred at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
4	within To th	M.	29b. Signature and title of certifier		29c. License number		Date signed (Month, )	Day, Year)
(	(1)		30. Name and address of person who ca	empleted cause of death (Item 23a)	(Type, Print) Ox 43 7.	0	1/16/0	
	Stat	te	31. Date filed (Month, Day, Year)	EIN 9801 GC	orgiative, silver)	only md	20802	

			for State Registrar	te of Maryla		artment of F rtificate of		, ,	giene Reg. No.	j	25284
E	Physici	an	1. Decedent's Name (First, Middle, Last)  James	L		Butler		2. Date of Dea Month	ath Day	Year	3. Time of Death
4	/Medio		4a. Facility Name (If not institution, give street a				r Location of Dea	July	21 20 4c. County of	07	2152p <sup>M</sup>
	LXaiiiii	CI	Holy Cross Hospita	,			er Spr		Monto		rv
×	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		8. Date of Birth	h /. Year)	9. Birthp	lace (State or Foreign
See File	Director		Usual Residence of Decedent	61	Yrs.			02/02/	1946	Mary	land
	land ow at		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	0d. Inside City Limits
	Many a-f sh ffied	ż	Maryland Montgomer	у	Silvei	Sprine	T .				1X Yes 2 □ No
	th the or 28a e not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	try?
	ath wi		13801 Castle Blvd.			20904			USA		
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Wa	s Decedent Ever in l ned Forces?  Yes 2 <b>X</b> No	J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Black	- America , White, e	
36	ırs aft   ', or  xami	by F	If Y	es, Give r or Dates:		1□Yes 2XINo	Specify:		Specify:	Blac	k
21215-0036	'2 hou natura ical E		15. Decedent's Education	(a.4a.d)	16a. Deced	lent's Usual Occup	ation		16b. Kind of Bus	iness/Ind	ustry
218	within 7 ene. than "r he Med	Completed	(Specify only highest grade comp  Elementary/Secondary (0-12)  Col	ege (1-4or 5+)	life. I	kind of work done OO NOT use retired	d)	orking			
	filed w Hygier ther th		12		Truc	k Drive			B.K. M		er
Maryland	d be fi	Be o	17. Father's Name (First, Middle, Last)		Butl	or		me (First, Middle,	Maiden Surname		
Z.	12 should be f h and Mental I r is marked of raumatic eve	잍	Henson 19a. Informant's Name/Relationship (Type. Prir	it)			Mary and Number or B	ural Route Numbe	r. City or Town S	JOI tate Zin	nnson <sup>Code)</sup> yland2090
Š	1 and 2 Health a em 27 is		Fern V. Butler/ Wi	fe	13801	Castle	Blvd	Apt33	Silver	Mar	yland2090
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal	20b.	Place of Dispo	sition (Name of natory or other place	1	Date	20c. Location - C	ity or To	wn, State
Ĕ	Page ment ant: It ury o		4 □ Donation 5 □ Other (Specify)	from State	etropo	litan C	rem.7/2	28/07 Z	Alexand	ria	Va 22310
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ang.		21. Signature of Funeral Service Licensee	-	22	. Name and Addre	ss of Facility Ac	lams Fun	eral H	ome	PA
	0.07 = 40.0	-	232 Cart Entaring diseases or amplications	that assumed the day	1 2	0605 Ag	<u>uasco F</u>	<u>ld. Aqua</u>	isco, M	aryl	Land20608
			23a. Fart1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final	1)		er the mode of dym	ly, such as cardia	ic or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ue to (or as a conse	LONIA					-	-
4	Examiner			Somic	quence oi).						
	D #	ner	Sequentially list conditions, if any, leading to immediate  D	ue or a la conse	ce of):						
	ecuted Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	tark	Kenn	Fai					
60,	be ext	ũ	Due to (or as a consequence of):								
68760,	fficate be executed g physician and as the burial-transit	edical	d								
Box (		n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	s, outcome pf pregn	ancy				23d. Date of delivery		
m	death e atte	icla	in the past 12 months?	Live birth 2 ☐ Fet Pregnant at time of		Ectopic pregnancy Other (specify)			Mont		Day Year
P.O.	at the by th tache	Physician/M	9 ☐ Unknown	Unknown							
Š,	res ti igne be c	þ	Part II. Other significant conditions contributing	to death but not res	sulting in the un	derlying cause give	en in Part I.				e cause of death?
oro	requi	sted						1 🗆 Ye	es 2 No 3	Proba	ably 450Unknown
Sec.	m (0 a)	Completed						24a. Was a autops	sy pri	or to com	sy findings available pletion of cause of
Vital Records,			OF Was appared to made a						2 No 1 [	ath? ]Yes 2	2 □ No
	/sicia s certi directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	1 Linpatient 2 □	] ER/Outpatient	3 DOA Othe	ar.	ath (Check only on			
0	ding Phy h. After thi funeral c	n: To	27. Manner of Death 28a.	Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		fome 5 ☐ Reside	ow injury occurred		)
Š	endin ath. or: Af he fur	atio	1 ► Natural 5 □ Pending 2 □ Accident investigation	(Monal, Day Teal)	Injury		Yes 2 □ No				
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (St City or Town	(Street and Number or Rural Route Number, own, State)		
	pital or Al		29a. Certifier 1 Certifying Physician:	To the heat of my key	owledge death	accurred at the ti-					
	e Hos 24 hc e Fun letely	edical	(Check only 2 Medical Examiner: On	the basis of examina manner stated.	ation and/or inv	estigation, in my o	pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and mani late and place, ar	d due to	the cause(s)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier		Λ	29c. License	number	2	9d. Date signed (	Month, D	Pay, Year)
			> hell la	undle	N	1) 2	20772	_	7/23	100	
(	Car		30. Name and address of person who completed		n 23a) (Type, F	Print)	, , ,		1/20/	-/	
(	PPP		TRA JAnnebaum  31. Date filed (Month, Day, Year)	32. Registrar's Signa	west	Glen Icc	1 Silver	Spring	mi)	2	910
	Stat Registra		JUL 2 5 2007	Allew .	J. A	parte		0	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 9:40 PM Physician BARTON ( Bay NORENE 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK COLLEGE CENTER VIEW TREDERICK If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 75 214-32-457 MD. NOV. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified... once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ✓ Yes 2 ☐ No FREDERICK FREDERICK MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BURGESS HILL 21702 100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DARKS Elementary/Secondary (0-12) College (1-4or 5+) SAVSAGE PACKER TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACKSON CHARLES SNOWDEN ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAY FREDERICK MD. 21702 (Husb) 100 BURGESSHIM BARTON WILLIAM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 24,2007 Burial 2 ☐ Cremation 3 ☐ Removal from State FREDER ICIR. FAIRVION COM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Liversee ROLLINS PUN HOME FREDERICK MD 21701 110 WEST SOUTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician remember /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause the discount of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician the burial Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? this certificate 1□ Yes 2 No Fo the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specity) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hemen Shah

32. Registrar's Signature

650

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Thomas

29c. License number

D0060417

Tohnson

29d. Date signed (Month, Day, Year)

I Records, P.O. Box 68760,	The law requires that the death certificate be executed
Division or Vital	To the Hospital or Attending Physician:

			Plea	se Type o								9		
		For State		State	of Ma	aryland /		artment of I <i>rtificate of</i>	lealth and	Mental Hy	/giene Reg. No		7 25283	
		Registrar  1. Decedent's Nam	ne (First, Midd	le, Last)				timodito or	Douth	2. Date of D	eath		3. Time of Death	
Physicia /Medic		Charles	s Lero	y Bootl	ı					July	22,			
Examin		4a. Facility Name (i							or Location of Deat	h	4c.	County of De	ath	
		7885 Mo		Harmony 6. Sex	_	e (In yrs. last I	hirthday)	O If Under 1 Year	wings if Under 24 Hrs.	8. Date of B	irth	Calvert		
Funeral Director		220-32-		1 <b>∑</b> M 2□F	_		2 Yrs.	Months Days	Hours Min.		ay, Year)			
PL ,		Usual Residence o					···-			3/20/	193	J		
larylar show	or	10a. State	10b. County			10c. City, To	WII OF LO		vings				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
the N 28a-f notifile	Director	MD 10e. Street and Nu		alvert				10f. Zip Code	vingb		10g. Cit	izen of What (		
h with 3a or st be	iQ le	7885 №	lount.	Harmony	T <sub>a</sub>	ne			20736		J	USA	,	
ems 2	Funeral	11. Marital Status	10 411 0	12. Was D		Ever in U.S.	13. V	Was Decedent of I f Yes, specify Cub	0-	14. Race - American Indian, Black, White, etc.				
be filed within 72 hours after death with the Maryland tal Hygiene. It has not then than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Marr 3 ☐ Widowed	4.	ried 1 X Ye If Yes,	s 2∐l Give	No F7 F0	1	I□Yes 2∏ No			B1ack			
hour houral		3 Wildowed		nt's Education	Dates:	57-59	Sa. Deced	lent's Usual Occu	pation		16b. K	ind of Busines		
hin 72 9. an "na Medic	plet	(Spec	cify only highe	est grade complete	d) (1-4or 5	5+)	(Give life. [	kind of work done OO NOT use retire	during most of wo. d)	rking				
ad wit ygiene er tha	Completed	11			(. 10. 0	(	Carp	entry 1				nstru	etion 	
be fill ad oth even	Be	17. Father's Name							18. Mother's Nar			Surname)		
hould id Mei marke matic	인	Leroy  19a. informant's N				10	9h Mailin	a Address (Street	Nai and Number or Re	nie Wii		or Town State	Zin Code)	
nd 2 suffh an 27 is r trau		Sylvia							armony I					
es 1 au of Hea item		20a. Method of Dis	position					sition (Name of natory or other pla		Date		ocation - City of		
Page nent c		1 <b>X</b> I Burial 2 4 ☐ Donation		3 □Removal fro Specify)	m State			rial Gd		8/07	Dun	kirk,	MD	
permit. Pages 1 and 2 should be filed within 72 ho pepmit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. once.		21. Signature of Fu	uneral Service	Licensee	•		22	. Name and Addre	ess of Facility	Raymon	d-Wo	od F.	H., P.A.	
005 60	_	02a Parti Entart	WO	Cy	4 0011000	I the death D			430, Du			20754	Approximate	
Physician		23a. Part1. Enter t shock, or hea Immediate Cause		t only one cause of	each lin	ge.	o not ente	er tile mode of dyl	ng, such as cardia	//		_ `	Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	p'n	a. Due	o (or as	a consequenc	e of):	aru	MOS	ale	nu	-C		
Examiner		Sequentially list co	anditions	b	01	de-	110	NSCI	1 lon	dro	211	RA.		
sit ed	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due	o (or as	a consequenc	e of):							
executed n and ial-transit	хап	that initiated events resulting in death)	S	c	o for as	e consequenc	e of):							
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death certificate be a strending physician for use as the buri	Physician/Medical	IE EEMALE.												
ath ce ttendii or use	ian/		Was decedent pregnant    23c. If yes, outcome pr pregnancy   1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy									23d. Date of d Month	elivery Day Y <i>e</i> ar	
he de the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4∐Pre 9□Un		time of death	5_	Other (specify) _				Monar	buy rou.	
		Part II. Other signi	ficant condit	ons contributing to	death b	ut not resulting	in the un	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute	to the cause of death?	
w requires to been signer should be	ed by									1 🗆	Yes 2	□ No 3□	Probably 4 Unknown	
e law re has ber je 2 sho	Completed									24a. Was	s an opsy	24b. Were	autopsy findings available completion of cause of	
	Com									perl 1⊟ Yes	ormed?	death1	?	
7 0 2	Be	25. Was case referexaminer?	_	Hospital:				Ott	26. Place of Dea		_			
Phys er this eral dii	2	1 Yes 2		28a. Da	☐ Inpatie te of Inju	ry 28b	. Time of	1 3L DOA	4 □ Nursing F	lome 5 Aes 28d. Describe			pecify)	
ath. rr: Afte	atior	1 ☑ Natural 2 ☐ Accident	5 Pendi invest	ng (M gation	onth, Da	y Year)	Injury		rk? ∣Yes 2∐No					
r Atte ter de Irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deterr	nined 200. Pla	ce of inju	ury - At home, c. (Specify)	farm, stre	et, factory, office			(Street an		Rural Route Number,	
pltal c		29a, Certifier	1 ortifui	ng Physician: To	ha hast	of my knowled	lac doeth	oncurred at the t	imo data and alsa					
To the Hospital or Attending Ph within 24 hours after deceth.  To the Funeral Director: After thi completely filled in by the funeral.	Medical	(Check only one)	2 ☐ Medica	Examiner: On the	basis of	f examination a	and/or inv	restigation, in my	opinion, death occi	urred at the time	, date and	d place, and d	ue to the cause(s)	
To th To th comp	Me	29b. Signature and	I title of certific	21	1			29c. Licens	a		29d. Da	te signed (Mo	nth, Day, Year)	
, , ,		- Ase	ad	1-h	1	1		DI	2705			1/24/	07	
4+1		30. Name and addi	ress of persor	who completed ca	use of d	eath (Item 23a	(Type, I	0	2103	Fred	A =	1	mh 2000	
Sta	te	31. Date filed (Mor	nth, Day, Year		Registra	ar's Signature	· D ·	•	Moce	1-50	eri	4	111) 900/2	
Registr		JUL	0.0			N. A	marke	1						

			For State Registrar	State of Maryla		tificate of	Death		eg. No.	3. Time of Death
14	Physicia	an	1. Decedent's Name (First, Middle, Lat	E	BANKS	- leter	(Son)	Month	20 2007	3:30 A M
100	/Medic Examin	_	4a. Facility Name (If not institution, give		7,,,,,,,		r Location of Death		4c. County of Deat	
			Future Care Pinev			Clinto			Prince Ge	
	Funeral Director		5. Social Security Number  577–52–9095  Usual Residence of Decedent	7. Age (In yn	3 Yrs.	if Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. 15	(Year) Co	hplace (State or Foreign untry) SCO, MD
	Maryland a-f show ified at	ctor	10a. State 10b. County Prince G		City, Town or Lo linton	cation				10d. Inside City Limits 1  Yes 2 □ No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 9106 Pineview Lar	ne		10f. Zip Code <b>20735</b>		1	0g. Citizen of What Co	untry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 <b>XX</b> No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	
15-0	in 72 ho n "natur Aedical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed) College (1-4or 5+)	16a. Deced (Give life, L	lent's Usual Occup kind of work done OO NOT use retired	oation during most of workir d)	ng	16b. Kind of Business/	Industry
212	d with giene er thau the N	mo.	6	College (1-401 5+)	Hou	sewife			Own Home	
e, Maryla	uld be file Aental Hy rked othe tic event	To Be (	17. Father's Name (First, Middle, Last James Johnson	)			18. Mother's Name	(First, Middle, owler	Maiden Surname)	
	and 2 should ealth and Mer n 27 Is marke her traumatic		19a. Informant's Name/Relationship ( Eugene McKenzie/n				and Number or Rura LN, Bowie, N		r, City or Town, State, 2	žip Code)
	Pages 1 ament of He ant: If item ury or othe		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		. Phillip	sition (Name of matory or other planes Cemetery	7–26-	-07	20c. Location - City or Aquasco, MD	Town, State
Balt	permit. P Departmi Importar any injur		21. Signature Funeral Service Lice	1 Jour	\ \ \T\	Name and Addre	ung Funeral	Svcs	719 Kennedy, Wash., DC 20	St., NW 011
	Physician /Medical		23a. Part1. Enter the disease, or com shock, theart failure. List only Immediate Cause (Final disease or condition resulting in death)		lerotic	58% 3000	ng, such as cardiac o	r respiratory ar		Approximate Interval Between Onset and Death YEARS
	Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b Due to (or as a cons	equence of):					
68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
		<b>ledical</b>	NE CENTRE							
.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detachèd for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf pred 1 □ Live birth 2 □ Fo 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnanc Other (specify)	y		23d. Date of de Month	livery Day Year
Δ.	s that the ned by detact	by Ph	Part II. Other significant conditions	contributing to death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	en sig							1 🗆 \	′es 2 <b>X</b> No 3 □ P	robably 4 ☐Unknown
Vital Records,	The law rate has be	Completed							an 24b. Were a prior to death? 2	utopsy findings available completion of cause of 2  No
/ita	Physician: this certificatal director, I	Be C	25. Was case referred to medical examiner?	Heopitals		l Out	26. Place of Death			
or/	Physical this call dire	ို	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2  28a. Date of Injury	ER/Outpatier	IL 3 DOA			dence 6 Other (Spenow injury occurred	cify)
on	Attending r death. sctor: After sy the funer	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year		Wo	rk? ]Yes 2 □ No		,,	
Division or	I or Atter after dea Director	Certification:	3 Suicide 6 □ Could not t 4 □ Homicide determined		t home, farm, st ecify)	reet, factory, office		28f. Location (5 City or Tox	Street and Number or R vn, State)	ural Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysician: To the best of my luminer: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and tile of certifier		71.	29c. Licen			29d. Date signed (Mon	
	(2)		30. Name a dr. ss of person who	completed cause of death (I	tem 23a) (Type,	Print)	243723	1	July 20, 2	JU /
			Philip Wisotsky, MD,				waldor, ML	20002		
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 2 4 2007	32. Registrar's Signature & A.	Sperke	,				

		ľ	For State Registrar	State of M	aryland		tificate of				giene Reg. No.	2007	2529	
ľ	Physicia	an	Decedent's Name (First, Mice     Eugenia Ell							2. Date of De Month	Day		3. Time of Death	
1	/Medic Examin		4a. Facility Name (If not institut				4b. City, Town,	or Location		uly	19,	2007 County of Death	10:00 a <sub>M</sub>	
?				re of Hagerst			Hage	n		Washington				
k	Funeral Director		5. Social Security Number 220-80-4412	6. Sex 7. Aq 1  M 2  F	ge (In yrs. las. 90	t birthday). Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birl (Month, Da 05/15/	Day, Year) Country)			
	and w		Usual Residence of Decedent  10a. State 10b. Coun	nty	10c. City, T	Town or Lo	cation						10d. Inside City Limits	
ING Z1Z13-UU36  be filed within 72 hours after death with the Maryland tital Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	tor	WV Berk	elev	Falli	no Wa	aters						1 <b>X</b> ]Yes 2 ☐ No		
	Director	10e. Street and Number		1 - 0 - 1 - 2		10f. Zip Code				10g. Citiz	zen of What Cou	ntry?		
	23a c ust b	ral	269 Cool Hollo	ow Drive			2541					USA		
<b>35</b> s after de	s after des ; or Items aminer m	by Funeral	11. Marital Status  1 Never Married 2 M.	If Yes, Give	?		Vas Decedent of I f Yes, specify Cub I ☐ Yes 2X No			eity Yes or No lican, etc.)		14. Race - Ameri Black, White, Specify:	etc.	
2-003p	2 hours	ted b	3 ☑ Widowed 4 ☐ Divorce	lent's Education		16a. Decedent's Usual Occupation 16b. Kin						Wh:		
121	within 7 sne. than "n	Completed	Elementary/Secondary (0-12	chest grade completed) College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired)  Homemaker								
7 0	filed v Hygie other t		17. Father's Name (First, Middle	lle, Last)		Hom	emaker	18. Moti	her's Name (	(First, Middle,		Domestic <sub>Surname)</sub>	<u></u>	
ıand	uld be Mental rked c	To Be	Bolden Dougl	las Sutphin				Mat	oel C.	Legg		•		
Mar	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relatio				g Address (Stree						Code)	
e,	ss 1 and 37 Health item 27 other tr		Dorothy Wilson 20a. Method of Disposition	n/Daugnter			Poplar R		Suilt			0746 cation - City or T	own State	
D E	Pages nent of i int: If its iry or o		·	n 3 Removal from State			sition (Name of natory or other pla 1n Cemet		07/24	/2007		ntwood,		
Бапппо	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service	ta omeny- Che	a Han	22		ess of Fac	ility Ft.	Linco	ln Fu		lome, Inc. 20722	
			23a. Part1. En er the disease, shock, or heart failure. L			-						July 112	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	HYPA	rti	n 5162						Onset and Death	
E	Examiner			Due to (or as	a consequer	nce of):	Fibr	illa	Tion					
	sit ad	iner	Sequentially list conditions, large cause. Enter Underlying Cause (Disease or injury	Disc to (or as	a consequen	100 (00)		, , ,						
,	ifficate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequer	nce of):								
09/90	ate be hysicia the bur	edical		d								-		
T	# Do a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnanc	у					,	3d. Date of deliv	env	
O. BOX	the death certi y the attending ched for use a	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnand Other (specify) _	:y 				Month	Day Year	
λ. F	ss that I	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to								se contribute to t	he cause of death?		
ecords	require een si			mentis						1 🗆 '	Yes 2	No 3∏ Pro	bably 4 dnknown	
Ē	ding Physician: The law requires that the de n. h. After this certificate has been signed by the a funeral director, page 2 should be detached	Completed								24a. Was autor perfo 1 Yes	osy ormed?	24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of 2 \( \) No	
NI G	Physician: r this certific ral director,	Be	25. Was case referred to medi examiner?	Hospital:			104			(Check only o				
5	Phys or this or	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inj	ent 2□ER ury 28	NOutpatien  Bb. Time of	1 3 L DOA			e 5 Resid		Other (Speci	fy)	
SION	Attending r death. ector: After by the fune	ation	1 ☐ Matural 5 ☐ Pend 2 ☐ Accident inves		y Year)	Injury	28c. Inju Wa M 1	rk? ]Yes 2[			,,	,		
	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	zmined   Zoe. Flace of III	ury - At home tc. (Specify)	e, farm, stre						reet and Number or Rural Route Number, r, State)		
	e Hospit 1 24 hours e Funera	edical	29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medic	ying Physician: To the best cal Examiner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred at the t vestigation, in my	ime, date a	and place, ar eath occurre	nd due to the d at the time,	cause(s) date and	and manner as splace, and due to	stated. to the cause(s)	
	To th Withir To th comp	Me	29b. Signature and title of certi	ifier			29c. Licen				29d. Date	e signed (Month,	Day, Year)	
			- and	muly	·				396		0	111312		
12	-(1)		30. Name and address of person	on who completed cause of a	leath (Item 23	3a) (Type, I	Print) 11 ~	6	Cal	ed (	ct.	v 0 2 1	740	
	Sta Registr		31. Date filed (Month, Day, Yea	ar) 32. Regist	rar's Signa	id		Hay	L->T	, ,		-11 4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 4:32 P M Catherine 20 Best July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 ₩ Yrs 83 Sep. North Carolina 340-24-2847 Director 1923 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 XYes 2 No Director Md Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 and 1 injury or other traumatic event, the Medical Examiner must be no any injury or other traumatic event, the Medical Examiner must be none. 1703 Terrapin Hills Drive 20721 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 ☐ KNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Sampson Cora Reid ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Sanford/Daughter 1703 Terrapin Hill Drive Bowie, Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elmwood Cemetery 7/27/2007 Goldsboro, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Functial Service Latinsee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TATAL **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending newsinian and attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 2)(No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

JUL 2 4 2007 State Registrar

(Check only one)

29b. Signature and title of certifier



30. Name and a sof person who completed cross of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

CHEVERLY, MD 20185

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		Please Type of Fills in black indelible lik. Elistic All Copies Are Legible.
		State of Maryland / Department of Health and Mental Hygiene
		State Registrar Certificate of Death Reg. No.
Physicia /Medic Examin	al	a. Facility Name (If not institution, give street and number)  2. Date of Death  Day  Year  1.05A M  4b. City, Town, or Location of Death  4c. County of Death
Examin	ζ.	Manor Care Nursing & Rehab. Center Wheaton Montgomery
Funeral Director		Manor Care Nursing & Rehab. Center Wheaton Montgomery Social Security Number 6. Sex 90 Yrs. Months Days Hours Min. Min. Oct. 26, 1916  Montgomery 9. Birthplace (State or Foreign Months, Day, Year) Oct. 26, 1916  Wash., DC
P .		Jsual Residence of Decedent
anylar show	L	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No
Ba-f	ecto	Md. PG Temple Hills
with t	P	Oe. Street and Number10f. Zip Code10g. Citizen of What Country?2604 Afton Street20748United States
death with the Maryland rns 23a or 28a-f show critist be notified at	erai	
	by Funeral Director	Amed Forces?    If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, etc.
21215-0036 d within 72 hours afgione. or than "natural", or	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Pan 'n A	pie	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)
d 21215- filed within 72 Hygiene. wher then "naten"	Completed	1 Postal Carrier U.S. Post Office
be fill the doth	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
aryla should ind Men in mark•	은	William H. Carter Edna Gordon
F 12 2		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  2604 Afton Street
_ č=0 L		Theresa Carter/Wife  Temple Hills, Md. 20748  20a. Method of Disposition  1 Disposition 3 Demoyal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)
		1 Burial 2 Stremation 3 Removal from State 4 Donation 5 Other (Specify)  Riverdale Crematory 8/2/07 Riverdale, Md.
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signate of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H.
D FOR FOR		January Edward 3910 Silver Hill Rd., Suitland, Md. 20746
8) 3 7		23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  aCORONARY ARTERY DISEASE  Onset and Death  Onset and Death
Examiner	_	Sequentially list conditions, b.  Due to (or as a consequence of):
Tied Tied	Examiner	causa. Enter Underlying
icate be executed physician and sthe burial-transit	Exal	that initiated events c.  Due to (or as a consequence of):
	cai	d
rtifical	Med	IF FEMALE:
HECONGS, P.O. BOX 687. The law requires that the death certificate ate has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	23d. If yes, outcome of pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown  23d. Date of delivery  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown
IS, P.(	/ Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Hecords, he law requires t has been signe ige 2 should be o	ed by	ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Bunknown
aw re	plet	HYPERTENSION  24a. Was an autopsy prior to completion of cause of prior to completion of cause of
	Completed	autopsy performed? performed? performed? the completion of cause of death?
f VITAL F ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical 26. Place of Death Check only one examiner?
Of V Physic r this co	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
On C	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of linjury 1 12 Natural 5 Pending 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time of linjury 28b. Time
ISIO Mtendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined.  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
DIVISION all or Attending s after death. If Director: After d in by the fune	Certification:	4 Homicide determined determined building, etc. (Specify)
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To th within To th	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		DO038521 JULY 26 2007
1811		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.,		SHILUAN GOSTAVE KARSER PERMANENTE ROCKUTILE MD.
Sta Registr		31. Date filed (Month, Day, Year)  AUG 0 7 2007  32 Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2146 07 21 Franklin 07 /Medical Cantwell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBURK Wicomico ENINSULA RECIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min. Director 84 178-18-3561 6-22-1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injoyrant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Village Oak Dr. by Funeral 21804 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 TYPes 2 No If Yes, Give Year or Dates: 194. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1942-1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No 1945 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Electrical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Dawson Cantwell ဥ Frances Adkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Cantwell - wife 125 Village Oak Dr., Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 7-23-07 Delmar, De<u>laware</u> 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. P. 11. Enter the disease, or cover cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Funk myocardial سمأنها /Medical Due to (or as a consequence of): Examiner Covenany arten Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe a No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Mapfier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 ☐ Pending investigation Injury Jopital C. 4 hours after dec. 4 hours after dec. . ...neral Director: Ahe 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours after
To the Funeral Dire 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41721 07 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY STEPHAN 400 E. SHORE DR. MD 21804 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records.

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

32. Registrar's Signature

**ORIGINAL** 

29c. License number 29d. Date signed (Month, Day, Year)

**Physician** 

/Medical

Examiner

10a. State

MD

11. Marital Status

12

Joseph

IF FEMALE:

1 Natural

2 Accident

3 ☐ Suicide

(Check only one)

29a. Certifier

**Funeral** 

Director

notified

"natural", or items 23a or 28a-f

**Physician** 

/Medical

Examiner

Director

Funeral

b

Completed

Be

ပ

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Month July 23, Chaney 5:30 A Helen Elizabeth 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Calvert Calvert County Nursing Center Prince Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 16, 19 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 X F Maryland 579-24-2692 1924 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Calvert Owings 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20736 U.S.A. 1116 Ontario Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Alle</u>n Elizabeth Wissman Burch Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1116 Ontario Court, Owings, MD 20736 Larry J. Chaney, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 07-27-07 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. ge of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the lisease, or complice shock, or heart fillure. List only one tions that caused the dealh. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause Final OMPLICATIONS OF ALZHEIMER) YFAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 ponths? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Yes 2 No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Examiner physician and the burial-transit Physician/Medical þ Completed Be ဥ Certification: within 24 hours after death.

To the Funeral Director A completely filled in by the fu Medical

State Registrar

31. Date filed (Month, Day, Year) 2 5 2007 JUL

OH~

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WF ITEL

1 🗔 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Dav. Year)

FREDERICE MIN-20678

32. Registrar's Signature Books

			1 - State of Maryland State of Maryland Registrar		tificate of L		, 0	ene g. No. 🥍 🎧 🧻 "	7 9590.
長	Physici	an	Decedent's Name (First, Middle, Last)     Linda Brown Cover				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	July 22,	4c. County of Dea	2:00 A M
		1	16701 Dorchester Place	nd fo indb alo)	Upper If Under 1 Year	Marlboro		1	George's
45	Funeral Director		5. Social Security Number  212–54–9618  G. Sex  1 □ M 2  F  7. Age (In yrs. last 58)  Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sep 9, 1	Year) Co	thplace (State or Foreign ountry) aryland
	yland now at			Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-f st ptified	Director		per Ma	arlboro				1 □Yes 2X No
	with the la or 20	Dire	10e. Street and Number 16701 Dorchester Place		10f. Zip Code 207	79	10	g. Citizen of What Co USA	ountry?
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Was Decedent of His f Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I∐Yes 2.1XINo		ritari, etc./	Black, Whit	White
Baltimore, Maryland 21215-0036	יח 72 hc "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired;	ation Juring most of work	ng 1	6b. Kind of Business	/Industry
212	d withir giene. r than the Me	omo	Elementary/Secondary (0-12) College (1-4or 5+)		cal Clerk			P. G. Cou	nty Gov't
nd	be filed tal Hygi d other event, ti	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Surname)	
ryla	2 should be f h and Mental     Is marked oi   raumatic eve	မှ	William Howard Brown  19a. Informant's Name/Relationship (Type. Print)	19h Mailin	a Address (Street a	Henriet		Bower City or Town, State, A	Zin Code)
<b>⊠</b>	s 1 and 2 sho of Health and item 27 is ma other traum:				Dorchest			Marlboro,	•
ore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		I M Buriai 2 □ Cremation 3 □ Removal from State		sition (Name of natory or other place	· · · · · · · ·	<sup>2</sup> 26	0c. Location - City or	Town, State
E I	nit. Pa artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify) Mou		View Cem  . Name and Addres			Ellicott C al Home Ca	
Ba	permi Depa Impo any it		Lary J. Goff		125 South	110			•
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to P as a conseque	ence of):	nta	rction			
	Examiner		Sequentially list conditions b.	ol cok	erol				
	ted sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	nce of					
o Î	execu an and rial-tran	Ехап	that initiated events resulting in death) Last C. Due to (or as a conseque	ence of):					
68760,	ificate be executed g physician and as the burial-transit	edical	d						
	± 0 €		IF FEMALE: 23c. If yes, outcome pf pregnant					23d. Date of de	livery
D. Box	le death cert the attending hed for use	Completed by Physician/N	in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
Д.	that the	y Phy	Part II. Other significant conditions contributing to death but not resulting	ing in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
ıds	equires en sign ould be	ed b					1 1	\$ 2 □ No 3 □ P	robably 4 □Unknown
Vital Records, P.O.	e law r has be	nplet					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
tal	an: Th tiflicate or, pag		25. Was case referred to medical			26. Place of Deatl	1□ Yes 2	No 1 ☐ Yes	3 2 □ No
ž N	hysicia his cer I direct	To Be	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   Ef	R/Outpatien	t 3 DOA Othe			nce 6 Other (Spe	ecify)
ouc	ding P. J. After t funera		1 ☐ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	Work	rat ? /es 2 ☐ No	28d. Describe hov	w injury occurred	
Division or	or Atten fter deatl Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.		29a. Certifier (Check only   1   Certifying Physician: To the best of my knowl   2   Medical Examiner: On the basis of examination	ledge, death on and/or inv	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ite and place, and du-	s stated. e to the cause(s)
	ro the vithin 2 ro the comple:	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	>F0		1 (x 9.055 mg	· •	D	3304	1	7/24/01	7
	12		30. Name and address of person who completed cause of death (Item 2 Eric Berstein, MD 133 De:		Print) Highway	Annapoli	s. MD		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire.		-11110FO-13	,		
	Registr	ar	JUL A J LOUI MENTER JO	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 2:10 PM 2000 UL /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tors YNCE (ommunit aN ham eorges 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Poreign Country) 6. Sex last birthday **Funeral** Months 1 □ M 2 😧 F Davs Hours 220-82-4380 47 1960 Virginia Director 31 Jan. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f sh Maryland Prince George's Glenarden 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 3503 Gary Court 20774 USA Funeral If Item 27 is marked other than "natural", or Items or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Medical Examiner. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetic Specialist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Alexander Chappell Dorothy Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Chappell/Father 20774 3503 Gary Court, Glenarden, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 7/25/2007 4 □ Donation 5 □ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastan east /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a prosequence of Physician/Medical Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2**Z** No 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 250 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To this uneral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation 1 Tes 2 🗆 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MBD 53718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 6008 LUCK ROAD LANKAM, MD M. D. 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Dorothy Cash July 24, 2007 7:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1162 Ebenezer Church Road Rising Sun Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 K F 221-10-1413 Director 87 March 24,1920 Wilmington, DE Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2x No Director PA Chester Landenberg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 Landenberg Road 19350 TISA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 20 No Specify: Specify: φ 35€Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tour Receptionist Winterthur Museum I. Pages 1 and 2 should be filed w tment of Health and Mental Hygie rient: If item 27 is marked other t ijury or other treumetic event, II. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Dermond Gertrude Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Cash (son) 238 Landenberg Rd. Landenberg, PA 19350 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Cemetery July 27,2007 Wilm., DE 21. Signature of Funeral Service Lices 22. Name and Address of Facility M00756 McCrery Funeral Homes, Inc. 3924 Concord Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Altheiners Physician Disease syears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sause. Enter Uncertains Cause (Disease or injury that introduced in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer 2 should be d ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital I or Attanding Physician: after death. Diractor: After this certifice director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Other (Specify) ASS is teal Living Hospital: 1 ☐ Yes 2 ZÑo funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours at To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 24/07 DOOU 48050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M9 15 S. Parke Street # 400 Aberdeen MD 21001 Prashant Shukla 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUI 2 5 2007 Registrar

The law requires that the death certificate be executed Ó م Division of Vital Records, within 24 hours after To the Funeral Dire the Hospital

**Funeral** 

Director

r than "natural", or Itams 23s or 28s-f show the Medical Examinar must be notified at

other than

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic svent

**Physician** 

Examiner

/Medical

the attending physicien and the for use as the burial-transit

signed by

has

this certificate

After

funeral dir

filled in by the

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/200

State

Registrar

Prince Frederick

30. Name and address of person the completed cause of reath (Item 23a) (Type, Print)

32. Registrar's Signature

Mathor

<sup>Year)</sup> 2007

31. Date filed (Month, Day,

25

		1 - For State Registrar	State of Marylar		rtificate of l		F	Reg. No.		2.5	29
Physic		1. Decedent's Name <i>(First, Middle, Las</i> Joshua No	rman Despeaux				2. Date of Dea	Day	Year <b>20</b> 07	3. Time of 0915	Death Am
/Med Exam		4a. Facility Name (If not institution, give Washington Coun	ty Hospital		4b. City, Town, or Hagers	Location of Death	0	4c. County	y of Death ngton		
Funera Director	_	5. Social Security Number 220-05-6051 X	ex	. <i>last birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1, 1918	9. Birthpla	ace (State of Vland	Foreign
e Maryland a-f show tified at	ctor	Usual Residence of Decedent  10a. State  Maryland  Trederi		ity, Town or Lo ederich						d. Inside Cit	
h with th 23a or 28 st be no	al Dire	10e. Street and Number 283 Pinoak Driv	re		10f. Zip Code 2170	1		10g. Citizen of U.S.A.	What Count	ry?	
CARLITIOTE; INIGITY IGILIA Z I Z I 3-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any night.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1.∑ Yes 2 □ No If Yes, Give Year or Dates: 19///-		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rai Bla Specil	ce - America ick, White, e fy: Whi	tc.	
within 72 he ene. than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation (de completed) College (1-4or 5+)	(Give	dent's Usual Occup e kind of work done o DO NOT use retired ma1 Caret	during most of work i)	king	Govern		ustry	
YIGHTIC Z 1 Z  build be filled with Mental Hygiene. arked other than attic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Frank Howard				18. Mother's Nam Nannie	e (First, Middle, Shankl	Maiden Surnai .e	me)		
i, INICITYICIII and 2 should be ealth and Mental n 27 Is marked o	-	19a. Informant's Name/Relationship ( Linda K. Despeau		19b. Mailii 12 Ke	ng Address <i>(Street l</i> eller Lan	and Number or Ru e, Middle	ral Route Numbe etown, M	er, City or Town laryland	, State, Zip ( 1 2176	Code) 9	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Eugene Arvid Diller .55 Ul 30 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 2 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days Months Hours Year) 1963 Mary Land Sept. 216-92-0984 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2KINo Md. Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19516 Air View Rd. 21740 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🕱 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold H. Diller Gail L. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie F. Diller/Wife 19516 Air View Rd. Hagerstown, MD. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place Paradise Mennonite Church Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 8/3/07 Hagerstown, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, PA. 17225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hortic Dissection horacis Due to (or as a consequence of) > Imo HARVEYSIA holecic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Due to (or as a consequence of) pregnancy □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ne of death 23e. Did tobacco use contribute to the cause of death?

Physiclan /Medical Examiner

and

the attending physician

signed by

this certificate has

within 24 hours after death To the Funeral Director:

completely

for use

Physician

/Medical

Examiner

Director

Funeral

Completed by

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner

burial-trar Physician/Medical þ director, page 2 should be Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □Live birth 2 4 □ Pregnant at tir 9 □ Unknown
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Part II. Other significant conditions of	ontributing to death but not resulting in the un	derlying cause given in Part I.
25. Was case referred to medical		26. Place of Death

	1 ☐ Yes	2	] No	3 ☐ Prol	bably	Unkr	own
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examiner? Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death  Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	c. Injury at Work?  1 Yes 2 No							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		office 28f. Location (Street and Number or Rural Route Nu. City or Town, State)	mber,						
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and manner stated

29c. License number

29b. Signature and title of certifier

00056965

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Hopersta mo

State Registrar

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Medical

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month July 22, 2007 1:30 a M Peter Anthony DiGiulio /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5977 Rockhold Creek Road Anne Arundel Deale If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1**√** M 2□ F Days Min. Hours 09/14/1936 Gouintry) 183-28-8639 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2□No Director MD Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20751 USA 5977 Rockhold Creek Read Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 Yes 2 ☐ If Mes, Give Year or Dates: 1 Never Married 2X Married 2 □ No Specify: White 1 ☐ Yes 2 ☑ No Specify à 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Federal Gov. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. DiGiulio Rose Ida Masciola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary DiGiulio/Wife 20a. Method of Disposition 5977 Rockhold Creek Rd. Deale MD 20751 ace of Disposition (Name of Date 20c. Location -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/24/2007 Clinton, MD Lee Crematory 22. Name and Address of Facilities Funeral Home Calvert, P.A. 21. Signature of Euneral Service Licensee Gary J. Part1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, As shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 15chenic disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) signed by the a ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2) 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 🗌 Yes 200 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Besidence 6 □Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 □ No not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b ature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 24,2007 Dr. Eric Marcalus 10 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Braverton Street Scrite 31. Date filed (Month, Day, 32. Registrar's Signature State 2 5 2007 Registrar

DHMH 17 Rev 1/2001

07-05695

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Granville Leroy Evans Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 25, 2007 0420 hrs Evans Granville Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not Institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min Months Days Country) 11/04/1982 Director 219-02-8398 24 Yrs 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Prince 10a State 'n 1 Yes 2 x No 23a or 28a-f show a notified at once. Landover MD George's Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 20785 3411 Dodge Park Rd. Apt.#203 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral must be r White, etc. Armed Forces? 1 X Never Married 2 Married Black. 2 X No Yes 2 X No specify: If Yes. Give Year es 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Widowed 4 Divorced ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Cook Baltimore, MD 21215-0036 12 18 Mother's Name (First, Middle, Maiden Surname) other t 17. Father's Name (First, Middle, Last) Griffin Sharon Granville Evans is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $3411\ \ Dodge\ \ Park\ \ Rd$  . Apt. #203 Landover, MD 20785 19a, Informant's Name/Relationship (Type, Print ) ၉ Sharon Evans/mother If item 27 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 8/3/2007 Lothian, MD Moses Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Home Fred., MD206 8 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ladis 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line. Death 'Medical Drowning complicated by phencyclidine use Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical X UNPENDED ##530.27,28a-f, perME,g870, 8/8/07 TT attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown signed by the z 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has b death? performed? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Division of Vital Be Other: examiner? Residence 6 Other Nursing Home 5 DOA 2 V ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Yes 2 X No subject drowned Pending d in by the f Fnd 7/25/2007 unk. 28f. Location (Street and Number or Rural Route Number, City 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 5001 Christiana Parren Rd. Suicide (Specify) found in swimming pool determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier July 25, 2007 O.C.M.E. Denna mulinenti, mid 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Pan, Year) 1 State Registrar

Donna M. Vincenti, MD

OCME

Assistant Medical Examiner

distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Deanna Lynn Farley State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day July 29, 2007 2124 hrs Medical Examiner DEANNA LYNN FARLEY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 1563 Main Street Whiteford If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral oreign Country) Months Days Hours Min. 160-52-8657 Director 46 11/20/1960 PΑ М 2× F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f shoy MD Harford Whiteford notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1563 Main Street 21160 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2X No White ŗ Divorce f Yes. Give Year Yes 2 X No specify. Specify Widowed other than "natural", the Medical Examiner ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene ant: If item 27 is marked other than "1 or other traumatic event, the Medical F Homemaker Own Home MD 21215-0036 10 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille McClure Charles R. Farley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1563 Main Street, Whiteford, MDCharles R. Farley/Father 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Department of Important: injury or other 8/3/2007 Hichview Mem. Gardns. Fallston, MD Donation 5 Other Specify 22, Name and Address of Facility grature of Funeral Service License Harkins Funeral Home, Inc., Delta, PA 17314 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** List only one cause on each line. een Onset and /Medical Death mmediate Cause (Final disease Smoke and soot inhalation Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of). W events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 4, 23a, 27, 28a-f, perME, g870, 8/16/07 TT attending physician or use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o þ σ. 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, has been si 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate h Yes 2 Nο ✓ Yes 2 the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other<sub>4</sub> Residence 6 V Other: Scene DOA Nursing Home 5 FR/Outpatient 3 this Inpatient 2 1 Yes No After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. Pending Yes 2X No accidental house fire Fnd 7/29/2007 Fnd 9:22 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be 1563 Main St. Whiteford, MD determined (Specify) residence Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 30, 2007 O.C.M.E. em NG 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

OCME

Er.c Hart

07-05867 UN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		1- For State	State o	f Maryland		rtment o <i>tificate o</i>			Mental I		> No	20	17 2501
Physicia	_	Registrar  1. Decedent's Name (First, Mid	idle,Last)							2. Date of De			3. Time of Death
edical Examii		CHAD ER	IC H	ART						Month July 31, 2	Day 2007	Year	2340 hrs
		4a. Facility Name (if not institu 4731 Block Route 1	tion, give :	street and number			4b. City, T Darlin		ocation of Dea	ith	4c. Cou Harfo	inty of Death ord	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	ast birthday)		er 1 Year		_	irth(MM/DD/Y	YYY) 9. Bir Foreig	thplace (State or
Director		197-66-6523	1XXI	M 2 F	26	Yr	Month:	s Days	Hours M	in. 8/1/2	1980		untry) PA
. au		Usual Residence of Decedent 10a. State 10b. Count	у		10c. City,	Town or Loca	tion						10d. Inside City Limits
*	_	PA Yo	rk			De1t	a						1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number					10f. Zip	Code			10g. Citizen o	of What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once.		133 Susquehan	na Ro	oad				17314				USA	
th with terms 2 st be n	Funeral	11. Marital Status 1 X Never Married 2	Married	<ol><li>Was Decedent Armed Forces?</li></ol>						Specify Yes or N to Rican, etc.)		Race - Ameri White, etc.	ican Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once				1X Yes 2 f Yes, Give Year 1/	No1(	o/oż ,_	Yes 2	V No	specify:		Spec	Whi	te
ours af	d b	15. Decedent's Education (Sp				16a. Decede	nt's Usual	Occupatio	n (Give kind o			of Business/	Industry
136 hin 72 hours afte e. than "natural", edical Examiner	lete	Elementary/Secondary (0-1:	2)	College (1-4 or	5+)	_		_	OO NOT use r	etired)		etic	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	12 17. Father's Name (First, Midd	le Leet)	_		Pool C	pera		Nathor's No.	me (First, Middle,		reati	Ori
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than matic event, the Medica	Be C	Craiq E. Ha						10		hleen Ar		•	
2121 ould be fil d Mental H s marked iic event,	10 E	19a. Informant's Name/Relatio		oe, Print )		19b. Mailir	g Address	(Street		r Rural Route Nu			e, Zip Code)
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental I tant: If item 27 is marked or other traumatic event,		Craig E. Ha	rt/Fa	ather	l áai	133	Susqi	ıeḥan	na Roa	d. Delta Date	PA_	17314	
or Hear tr		20a. Method of Disposition  1 X Burial 2 Cremati	on 3	Removal from St		Place of Dispo crematory or o	sition (Nan ther place)	ne or ceme	etery,	Date	20c. Locat	tion - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other 21 Signature of Funeral Servi			Sus	sque. M	lemor			/6/2007	York	, PA	
Bal permi Depa Impo injur	- 1	21 right ture of Furieral Servi		toppelle	1.				•	ome, Inc	. Del	ta D	A 17314
Physician	7	22a. Part. Liter the disease, failure. List only one caus	or complic	cations that caused	the death.	. Do not enter	the mode of	of dying, s	uch as cardia	or respiratory a	rest, shock, o	or heart	Approximate Interval
/Medical aminer	4	Immediate Cause (Final disea	se a. M	Tultiple Injuries	1								Between Onset and Death
		or condition resulting in death	Di	ue to (or as a cons	equence of	f):				25			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		ue to (or as a cons	equence of	f):						100	
JA	Examiner	(Disease or injury that initiated events resulting in death) Las		ue to (or as a cons	equence of	f):							
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60, ate be ex ohysician ne burial -		IF FEMALE:		23c. If yes, outcome	me of preg	nancy					23d. Da	te of deliver	y y
Ox 6876(eath certificate attending phyrer for use as the b	ian/	23b. Was decedent pregnant in past 12 months?	the	1 Live birth 4 Pregnant at		2 F	etal death	3	Ectopic preg	nancy	Mon	ith [	Day Year
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s, P.O. Box ires that the death signed by the atte d be detached for a	by Pt	Part II. Other significant cond	ditions o	contributing to deat	h but not re	esulting in the	underlying	cause giv	en in Part I.				the cause of death?
S, F quires 1 en sign	ted t									- 24a. Was			bably 4 Unknown utopsy findings available
SOFC law re- has be 2 sho	Completed									auto			completion of cause of
of Vital Records, ig Physician: The law requirement the this certificate has been some all director, page 2 should I		25.14						00 P/		1 ✔ Yes	2 No	1 🗸 Ye	es 2 No
Vital hysician this cert	o Be	25. Was case referred to medi examiner?		spital: 1 Inpatie	ent 2	ER/Outpatien			ther Nur	sing Home 5	Residence	6 ✔ Othe	r: Scene
of \officers	-1	1 Yes 2 No 27. Manner of Death		28a Date of Init	ırv	28b. Time of		28c. Injury		28d. Describe	how injury o	ccurred	
ion trendir leath. tor: A	aţio		nding estigation	Jul 31, 2007	our)	2315 hrs		1 Ye	s 2 🗸 No	Passenger	auto auto	collision	
Division ospital or Attendir chours after death.  uneral Director: A	rtific	3 Suicide 6 Co	ould not be termined	28e Place of In				, office bui	Iding, etc.	28f. Location or Town, 4731 Block			ural Route Number, City
Division of No the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medical Certification:			n: To the best of m	y knowled	ge, death occu	rred at the			nd due to the cau	ise(s) and ma	nner as stat	ed.
To the within To the comp	Medi	29b. Signature and title of certi	а	and manner stated.	Time dom di			c. License		a at the time, date			onth, Day, Year)
	5	Allina Br	ass	( MI	>			O.C.M				1, 2007	, 20,, 1000,
10		30. Name and address of personal Melissa Brassell, MD		mpleted cause of d sistant Medica	_		Penn St	reet, Ba	Itimore, M	D 21201			
St: Regist	ate rar	31. Date filed (Month, Day, Yea	7 20	32. Registra	r's Signatu	ire	rett s	,					
DHMH 17 Rev 1/20	_			J. Carrier	The state of	ORIGINA	L						

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 7 2007

30. Name and address of derson who completed cause of death (Item 23a) (Type Print)
Sunil Gupta M.D. 625 Kent Avenue Cumberland MD 21502

32 Registrar's Signature

D0033280

2007

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			nent of Health and locate of Death	Reg. No.	007 25305
	Physicia /Medica	Decedent's Name (First, Middla, Last)  WILLIAM JOSEPH HAIG		2. Data of Death Month Day JULY 17	Yaar 2007 12:22 PM
	Examine	4a Facility Nama (If not institution, give street and numbar)  101 WINDWARD COURT	4b. City, Town, or STEVENSV	Location of Daath 4c. Co	unty of Death
	Funeral Director	5. Social Security Number 1 M M 2 F 7. Aga (In yrs. last birthday) More 1 M M 2 F 78	Inder 1 Year   If Undar 24 Hrs. htths Days Hours Min.	8. Data of Birth	Birthplace (State or Foraign Country)
	ath with the Maryland s 23a or 28a-f show wat be notified at	Usual Residence of Decedant  10a. Stata  10b. County  10c. City, Town or Location  MARYLAND  QUEEN ANNE STEVENSVILLI			10d. Insida City Limits 1 ☐ Yas 2 🛣 No
	vith the Ma		f. Zip Coda	10g. Citizer	of What Country?
	ath w	101 WINDWARD COURT	21666		D STATES
020	within 72 hours after death with the Maryland ena. than "naturat", or items 23a or 28a-f show its Medical Examiner must be notified at	1 ☐ Never Married 2 ☑ Married 1 💹 Yas 2 ☐ No	acadant of Hispanic Origin? (S specify Cuban, Maxican, Puart as 2 <b>∑</b> No <i>Spacify:</i>		Race Amarican Indian, Black, Whita, etc. ecity: WHITE
Baltimore, Maryland 21215-0020		15. Decedent's Education (Specify only highest grada complated)  Elamantary/Secondary (0-12)  Collega (1-4or 5+)  2  16a. Decedent's (Giva kind of life. DO No.	Usual Occupation of work dona during most of wor Tusa ratirad) INER	rking	of Businass/Industry
and	tal H	17. Fathar's Nama (First, Middle, Last)  JOHN W. HATG	18. Mothar's Nan	na (First, Middla, Maiden Sui	
ary.	should be nd Manta marked umatic ev		MAKGERA  Iress (Straat and Numbar or Ru	TE CHAPEWSKI	own Stata Zin Code)
Ž	and 2				MARYLAND 21666
nore	of He	20a. Method of Disposition  1 ☐ Burial 2 【A Cramation 3 ☐ Ramoval from Stata  20b. Place of Disposition camatary, cramatory	(Nama of or other place)	JULY 19 20c. Locati	ion - City or Town, Stata
altir	보 는 건 글 .	4 Donation 5 Other (Specify)  CHESAPEAKE ( 21. Signature of June/al Service Licensee 22. Nam	a and Addrass of Facility		SVILLE, MARYLAND
m	Depa Impo eny i		WS, HELFENBEIN HAMROCK ROAD,		UNERAL HOME, P.A.
The state of	Physician /Medical Examiner	23a. Peri1. Enter the disaasa, or complications that ausad the death. Do not anter the shock, or heart failure. List only one cause of each line.  Immediate Causa (Final disaasa or condition resulting in death)  a. Dua to (or as e consequence)		or raspiratory errest,	Approximate Interval Between Onsat and Death I, SYCOVS
ox 68760,	certificate ba assouted rights by sicien and use es the burlel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last  b. Dua to (or as a consequence c			
Box	death e attar	Part II. Other significant conditions contributing to death but not resulting in the underly	ng cause given in Part I.	23b. Did tobacco use	contributa to the causa of death?
s, P.O	v requiras that the death certifuents of the standing should be detached for use as a feet by Physician Ma.	prostate cancer		1   Yes 2   N	
Vital Records, P.O.				24a. Was an autopsy performad?	24b. Ware autopsy findings availabla prior to complation of causa of death?
	Physician: The la r this certificate has arel director, page 2 n: To Be Comm			1□ Yes 20 N	o 1 Tyes 2 No
	hysician: his certification of director To Be	25. Was casa refarred to medical axaminer?  1 □ Yas 2 □ No  Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □	26. Placa of Deal	th (Chack only ona) oma 5. Residence 6 □	Othor (Specific)
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	ne hospital or Attending Physician: in 24 hours after death in 24 hours after death pletaly filled in by the funerel director, edical Certification: To Be (	2 Accident investigation 3 Suicide 6 Could not be datermined 28e. Plece of Injury - At homa, farm, straat, far building, afc. (Specify)	1 ☐ Yas 2 ☐ No	28f. Location (Straat and No City or Town, Stata)	umbar or Rural Route Number,
	Hospita 24 hours Funeral etaly fille	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur of the basis of examination and/or investigal and manner stated.	ed at the time, date and place, tion, in my opinion, death occur	and due to the cause(s) and red at the time, date and pla	manner as stated. ce, and due to the cause(s)
	within To the comple	29b. Signature and title of certifier	29c. License number	29d. Date sig	gned (Month, Day, Year)
	JP	Janese Weins, MD	D2 68 20	July	18,2007
	10	Januse Wein, MD  30. Nama and eddress of person who completed cause of daath (Itam 23a) (Typa, Print)  Hank Wevne MD 900 Bes  31. Date filed (Month, Day, Year)  32. Registrar's Signatura	tgate Rucd+	±300, Anno	ropis, MO ziyor
	State Registrar	31. Date filed (Month, Day, Year) 32. Regignar's Signatura	2		-

DHMH 16 Rev 6/95

Registrar

State

31. Date filed (Month, Day, Year)

JUL 25

egistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month RMA 2007 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY - MEDICAL ENTER Wicomico KEGIONAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛺 Director death with the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at 1 PYes 2 No Director 10e. Street and Numbe 10g. Citizen of What Country? Department of Health and Mental Hygiene. Introducing them 23a or important; if item 27 is marked other than "natural", or items 23a or important; if item 27 is marked other than you jujury or other traumatic event, the Medical Examiner must be note. 3053 5 Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pla 1 ☐ Burial 2 Cremation 3 □Removal from State REMATORY OF DELMARUA 7-2 ElMAR 4 ☐ Denation 5 ☐ Other (Specify) 2) Signature of Funeral Service Licensee P.O. Box 27 Beidgeville DE 19953 HARRIS NOCK HUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic adeno ca cinmo /Medical Due to (or as a consequence of): Examiner Minth Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**o 1 Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 🗌 No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a To the Funeral L

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

and manner stated.

D.0 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

5

29c. License number

140064534

29d. Date signed (Month, Day, Year) 70/cs

SAlisbury Md. 21801

State Registrar 31. Date filed (Month

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend state of Maryland Department of Health and Mental Hygiene

Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician WILLIAM Μ. **JOHNSON** 10 2007 12:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year II Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 255 - 28 - 1279 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months t**∑**M 2□ F 83 Director 1923 SOUTH CAROLINA 1, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be natified at 10d. Inside City Limits 1 XYes 2 No Director MONTGOMERY SILVER SPRING 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 LOWANDER LANE 20901 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status fited within 72 hours after Hygiene. other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 Is marked other the eny injury or other traumatic event, that, once. ENTREPRENEUR PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM P. JOHNSON ABBIE CORLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAGGIE C. JOHNSON/WIFE 711 LOWANDER LANE SILVER SPRING, MD. 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) LINCOLN CEMETERY 7/18/07 BRENTWOOD, MD. 21. Sign ture o Funeral Service Licent ee 22. Name and Address of Facility CAPITOL MORTUARY hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. D.C. 20002
Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, of conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as e consequence of): Examiner HEPATOCELLULAR CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown detach ρ s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2√⊋ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy 2/ No 1 Yes 2 🔀 No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death | Check only one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending investigation To the Hospital or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the ft. death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 64699 Des Juple Keyal 7/ 11/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DASGUPTA 7600 KAJAL CARROLL AVENUE, TAKOMA PARK, MD. 32. Registrar's Signature 31. Date liled (Month, Day, Year) State 2 4 2007 Registrar

DHMH 17 Rev 1/2001

07-05790 William Klipp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Di vivi	R	Registrar  1. Decedent's Name (First, Middle,Last)	o or Bodin	Reg. No 2. Date of Death	3. Time of Death
Physicia edical Examir		William Todd Klipp		Month Day July 28, 2007	Y <sup>ear</sup> 1710 hrs
ball Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
		6636 Washington Boulevard	Elkridge		Howard
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24F	lrs. 8. Date of Birth(M	M/DD/YYYY) 9. Birthplace (State or
Director		215-90-0569 1xm 2 F 40	Months Days Hours M	11/07/19	Poreign Country) Maryland
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any and any and any		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
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Maryland 28a-f show d at once.	왕	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
or 28	Director	6636 Washington Blvd.	21075	111 141	USA
with the Maryland ns 23a or 28a-f sh		11. Marital Status 12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian, Black,
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21215-0036 uld'be filed within 7 Mental Figgiene. marked other than	Be	George Herbert Klipp, Sr.		da Ramona I	
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Baltimore, bermit. Pages I an Department of He Important: If ite		21. Signature of Funeral Service Licensee			Funeral Chapel
E 20 % E	_	23a. Part I. Enter the disease, or complications that caused the death. Do not	1601 Pennsylvan	ia Avenue,	Hagerstown Md 21742 shock, or heart Approximate Interval
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Division of Vital Records, P.O. Box 68760, To the Hospital of Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funcara Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner:On the basis of examination and/or in	th occurred at the time, date and place	, and due to the cause(s red at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To the Hos within 24 h	Medical	and manner stated,	29c. License number		29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier	O.C.M.E.	1	
		Mayone The Thele	O.C.IVI.E.		, 
		30. Name and address of person who completed cause of death (Item 23a)	111 Penn Street, Baltimore, I	MD 21201	
		Margarita Korell MD. Assistant Medical Examiner  31. Date filed (Month. Day, Year)  32. Registrar's Signature	Tit i enn Sueet, Daitimore, I		
Regi:	itate strai	2007 6	parle		
			IGINAL		
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State of Maryland / Department of Health and Mental Hygiene

		_	For State Of Maryland Registrar	-	tificate of l		,	Reg. No.	17 2531			
Phys /Mc	sicia edica	n	1. Decedent's Name (First, Middle, Last)  Louise Virginia Lacey				2. Date of Dea Month July		3. Time of Death 7 3:15A			
Exa		_	4a. Facility Name (If not institution, give street and number)  16503 Rolling Tree Road		4b. City, Town, or	Location of Death		4c. County of [				
Fune Direct			5. Social Security Number  5. Social Security Number  6. Sex  1 □ M 2 □ XF  9.3  Usual Residence of Decedent	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day August 2	h 9. y, Year)	Birthplace (State or Foreign Country) Maryland			
Maryland -f show fled at			10a. State 10b. County 10c. City	Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 No			
ath with the 23a or 28a ust be noti		<u> </u>	10e. Street and Number 16503 Rolling Tree Road	ORCER	10f. Zip Code 20607			10g. Citizen of Wha	t Country?			
urs after dea		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes ② ○ No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2iXNo	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V Specify:	American Indian, White, etc. White			
be filed within 72 hours after death with the Maryland trail Hygiene.  And Hygiene.  And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	lent's Usual Occupi kind of work done o OO NOT use retired	ation during most of wor l)	king	16b. Kind of Busin	ess/Industry			
be filed ntal Hygi od other event, t		å	12 17. Father's Name (First, Middle, Last) John Montgomery	Op	perator		ne (First, Middle, e Montgo	Telep Maiden Surname)	hone			
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permit. Pag Department Important: I any injury o	once.		21. Signature of Funeral Service Licensee M0094	5 22	Name and Address AREHART-E	s of Facility CHOLS FU	NERAL HO	OME, P.A.	20646			
Physiciae / Medic Examin / Medic Examin / Bhysiciau and as the purial-transit	al er	Physician/Medical Ex	Physician/Medical Ex	hysician/Medical Ex	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a representation of the cause of the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause).  Due to (or as a consequence of the cause).	ence of):	r the mode of dyin				Approximate interval Between Onset and Death	
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	١.	10 8	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 E	ER/Outpatient 28b. Time of Injury ne, farm, stre	28c. Injury Work M 1 🗆 Y	4 LI Nursing H	ome 5X Resid 28d. Describe h	dence 6 Other (sometimes of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the followin	Specify) r Rural Route Number,			
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To the within To the comple	:	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (M				
NRF			30. Name and address of person who completed cause of death (Item:	()	Print) taway	Rd SL 1	m Clin	Hom Mi	23,200=			
Regi	Stat	٠	31. Date filed (Month, Day, Year) 32. Redistrar's Signati	ure	4	Je G	W CIII	110711-110				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:50 AM 23, 2007 4c. County of Death Larson Leland /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dicomica Salisburg Rehabe Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (hars. last birthday) lisbur If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1∭ M 2□ F 10-22-1909 Director 97 North Dakota 477-05**-**5525 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 Philip Morris Drive 21804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1942 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Well Drilling Company 11 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Olson Lloyd Arthur Larson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cedar Drive, Salisbury, Maryland 21804 Linda L. Goldwire - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 7-27-2007 Salisbury, Maryland Wicomico Memorial Pk.: 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Figure Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Year-Per 20 /Medical Due to (or as a consequence of): **Examiner** 4 Sequentially list conditions, if any, searing to include a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 → No 3 □ Probably 4 □ Unknown 1 TYes Completed funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate I 2 240 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ → 100 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending within 24 hours after death To the Funeral Director: filled in by

death with the Maryland

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

1 2 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Robins, . 200 MiD 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

Medical

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To the Func

Division or Vital Records, P.O. Box 68760, 24 hours after death e Funeral Director: within 2

> State Registrar

GEORGE WATHEN 31. Date filed (Month, Day

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

end manner stated.

11345 PEMBROOKE SQ. SUITE 103 WALDORF, MD 20603

29c. License number

D- 20629

29d. Date signed (Month. Day. Year)

Z

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 20, 2007 3:15 p<sup>M</sup> Lillian Emma Mack July 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 8111 Forest Glen Road <u>White Plains</u> Charles 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 H Birthplace (State or Foreign Country) Days 91 Pennsylvania 218-30-4295 Jan.24,1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 U.S.A. 8111 Forest Glen Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret White Earl C. Peters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter 4775 Bicknell Rd., Marbury, Md. 20658 Nancy Speake 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Trinity Memorial Gardens 25, 2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Waldorf, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRYTH MI'A W HRS Due to (or as a consequence of): HYPERTENSIVE DISEME HEART Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2√No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner burial-transit Box 68760 pe

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Records,

Division or Vital

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than

permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and and Important: If Item 27 is any injury or other trauonce.

Baltimore, Maryland 21215-0036

/Medical

Examine the attending physician hed for use as the buria Physician/Medical signed by the a cate has been signal page 2 should b this funeral After t To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

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29c. License number

29d. Date signed (Month, Day, Year)

To the Hospital within 24 hours at To the Funeral D

State Registrar egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

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<u>च</u>	uld b Ment arked aric e	P	Pet	e McKay						Nancy Rose					
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or It								ural Route Number, City or Town, State, Zip Code)				
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766									P.A.			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 4:10 P M Dorothy McCardell Ju<sub>1</sub>y 21 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3913 Lawrence Street Colmar Manor Prince George's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 K F 106-24-4152 Feb. 6, 75 1932 New York Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State ral", or Items 23a or 28a-f show Examiner must be notified at 1x Yes 2 No Colmar Manor Prince George's Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20722 3913 Lawrence Street USA and 2 should be filed within 72 hours after death or ealth and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2K Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: White À Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Liquori Donata Romano ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3913 Lawrence Street, Colmar Manor, MD item 27 Stanley McCardell/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a, Method of Disposition Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery July 26,2007 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Since fur of Funeral Service Licens 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DENDCARC **Physician** 8 MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a.ry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No or Attending Physician; completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28b. Time of after death. 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 🖂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier MY) person who completed cause of death (Item 23a) (Type, Print) ROAD # 201 CLINTON MD 20735 WOODYARD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signa

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Department Certificate		al Hygiene 007	25317				
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Jar	2 sho and is ma	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (	Street and Number or Rurel Rout						
	1 and 1 Health am 27 i	TIFFANI MARKS / DAUGHTER 4114 MARBO		WASHINGTON, MI e 20c. Location - City of					
or or	ges 1 a it of Heam If Itam or othe	XX Burial 2 □ Cremation 3 □ Removal from State	er place)						
Baltimore,	t. Pa tmen tant: vjury	4 Donation 5 Other (Specify) RESURRECTION C		3/07 CLINTON,					
Bal	permit. Pages of Popartment of Himportant: If its any injury or of phice.		Address of Facility LL'S FUNERAL HO UITLAND ROAD S	OME OF MARYLAND SUITLAND, MD 20					
	*	23a. Pagt. Entar the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.			Approximata Interval Batwaen				
1	Physician /Medical Examiner	Immediate Causa (Final disease or condition rasulting in death)  a. PNEUMONIA  Due to (or as a consequence of):			Onset and Daath				
	executed in and ial-transit	b							
	cata be executed physician and sthe burial-transit	Sequentially list conditions, Dua to (or es e consaquance of):  If any, leading to immediate							
38760,	icata be e physician s the buni	cause. Enter Undartying Cousa (Disassa or injury that initiated avants  Due to (or as a consequence of):		+					
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Вох	death certifi e attending od for usa as	d			1				
	death	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I. 2	3b. Did tobacco usa contribu	te to the cause of death?				
P.0.	as that the death certifigned by the attending be datached for usa a			1 ☐ Yes XXX No 3 ☐	Probably 4 Unknown				
Records,	aw requiras is bean sign 2 should be		24	4a. Wes an autopsy performed?	o. Were autopsy findings available prior to completion of cause of death?				
ш Ш	The ata h			1□Yes XX.No	1 ☐ Yes 2 ☐ No				
of Vital	Physician: The k this certificata har al director, paga	25. Was case referred to medical	26. Place of Death (Chec	ck only one)					
7	Physician: this certific ral director,	1 Yes XXNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		X Rasidance 6 □Othar (Sp	pecify)				
	ttanding P death. stor: Aftar t r tha funer	27. Manner of Death 28e. Data of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	Work?	28d. Describe how injury occurred					
Sic	Attanding or death.  Ctor: Aftar by tha fune	2 Accident invastigation M 1 Tes 2 NO  3 Suicida 6 Could not be age Blees of Isium. At home term street feature office. 28f Location (Street and Number of Bl							
Division	after death Director: / d in by tha	4 Homicida datarmined building, atc. (Specify)		City or Town, State)					
	hou hou liner ly fill ly fill	29a. Certifiar XXX Certifying Physician: To the best of my knowladga, death occurred at (Check only 2 Medical Examiner: On the basis of exemination end/or investigation, in	tha time, data and place, and du n my opinion, daath occurred at t'	a to the causa(s) and manner he time, date and place, and d	as stated. ue to the cause(s)				
	within 24 Within 24 To the Fu	one) and mannar stated.  29b. Signature and title of certifiar 29c.	Licansa numbar	29d. Data signad (Mor					
	5 t i i	250. Shariature and miles of continual	\						
Ļ	(2)	80. Nama and ordrass of person who completed cause of death (Item 23s) (Type, Print)	) D28079	JULY 17,	, 2007				
L	-13/		חח אפדו בחווחיי	TAPCO MD	20785				
	State		00 BASIL COURT	LARGO, MD 2	20703				
	Registra	1111 9 / 2007							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 8-2-2007 Physician SHIM N/M/NNG 7:15P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GENESIS WALDORF CENTER WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9 – 22 – 1918 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 129-62-23∮9<sup>1□M 2</sup>ͿͿͰ 88 CHINA Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The marked other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh 1 ☐ Yes 2 No CHARLES MD. WALDORF Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or ' Examiner must be n 4140 OLD WASHINGTON ROAD 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: ASIAN þ 3 ☐ Xidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KITCHEN HELPER 6th RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHU YEE LING SUEY OI HUEY မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WINNIE ENG-DAUGHTER 13045 ZEKIAH DR. WALDORF,MD.20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important; If Ite any Injury or ot 1 □ Surial 2 □ Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) LORRAINE CEMETERY 8-11-07 BALTIMORE, MD. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Mgo479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 uc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death DVEN CRED MYETHSTATEC CANCER UNKNOWN PROMPHLY Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-trar Due to (or as a consequence of) attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day

**Physician** Examiner

altimore, Maryland 21215-0036

ed by the a sate has been signed by page 2 should be detach

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

Physician/Medical ₽ Completed Be Certification: To

in the past 12 months? 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown

25. Was case referred to medical examiner?

4 | Homicide

4□Pregnant at time of death 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Tyes

1 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one)

WALDORF, MU

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Hospital: 1 ☐ Inpatient Other: 4 Moursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 24ZîNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

miten

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

39. Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

Medical

completely

To the I within 24

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2007 12:34 PM JULY 22 CHRISTIE NGWE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🔀 F Director 214-33-2294 40 March 4 1967 CAMEROON Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1√∑Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20903 Funeral 1037 QUEBEC TERR # U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ACOBTA LYDIA ANWI DAVID ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROGERS TABREY/COMPANION 1037 QUEBEC TERR # 2 SILVER SPRING, MARYLAND 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Family 1 8/24/2007 CAMEROON, WEST AFRICA 4 ☐ Donation 5 ☐ Other (Specify) Plot 21. Signature of Quieral Service Lisensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 M Approximate Interval Between Onset and Death 23a. Part1. Enter the Tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARCINOMA WITH METASTAS **Physician** /Medical Due to (or as a consequence of): Examiner EPTICEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DIFFICILE COLITIS rsician and ₃ burial-tran Due to (or as a consequence of): physician the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy perform 1∐ Yes 2X No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Inpatient Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JAAM (W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAMIM, WASHINGTON MOVENTIST HOSP, TANOMA PARK 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month Nuka FISIC JUL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore UMMC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F 30 Director Unknown Aug 20 1976 Cameroon C.A Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-: any injury or other traumatic event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1√∑Yes 2 ☐ No Director Md Montgomery Silver Spring 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code 138200 Castle Blvd 20904 Cameroon, Central Africa Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ∏ No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student 4 vrs None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Nuka ٩ Mary Nuka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Sopa/Brother 6717 Riverdale Rd # G Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ⊠Removal from State 4 Donation 5 Dother (Specify) 8/1/2007 Cameroon, Central Africa Family Plot 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain **Physician** HYGKIC uks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HMOXID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed moke CENTICUE TON NO SECOND BY and that initiated events the burial-trai resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2☑ No 24a. Was an 1□ Yes 2 TNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No June 28, 2007 2 Accident 0400

Division or Vital Records, P.O. Box 68760, To the Funeral Director: After this certific completely filled in by the funeral director, or after

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont)

29b. Signature and title of certifier

6 Could not be determined

3☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

JUL

Greene Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated.

18230

House

13820

Baltimore, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2007

Castle Blvd

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 5:35 a. № 2007 Maxine Purtlebaugh July Donna 28 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Moran Manor Nursing Home Westernport **Allegany**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 X F Months Days Yrs. 384-14-7981 85 Martín, **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examents must be motified at 1 ☐ Yes 2 No Directo VA Frederick Winchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1413 Baker Lane 22603 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be itied within 72 hours after a Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or itel importent: or other traumatic event, it is Medical Exama any injury or other traumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 \ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lorena Glenn Smith Charles Lemuel Rotruck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Keyser, WV Judy George/ Niece Rt. 1, Box 204-A1 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 2007 Knobley Memorial Gardens ` 4 ☐ Donation 5 ☐ Other (Specify) Martin, WV 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Smith Funeral Home Rt. 2, Box 1-A Burlington, WV 16 man 26710 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) n' cute **Physician** Phenon A /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 💆 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Ucito Cummy 1 Yes 2 No 3 Probably 4 Hown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 25 Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2X No 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 124 hours a 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29c. License number 29b. Signature and title of certifier 321244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg, MD Jesus Tan, M.D. 4 Broadway 21532 32 Registrar's Signature 31. Date filed (Month State Registrar

07-05772 Andres Perez

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certific	ate of	Death		F	Reg. No.	E. L. C.	
Physici		1. Decedent's Name (First, Mid	dle,Last)					2. Date of De	ath	V	3. Time of Death
Medical Exam	iner	Andres refer.	Jr.					Month July 27, 2	2007	Year	2308 hrs
		4a. Facility Name (if not institut Atlantic General Hos		er)	41	City, Town, o Berlin	or Location of	Death	4c. Cou	nty of Death Cester	
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. last bir	thday)	If Under 1 Ye	ear If Under	24Hrs. 8. Date of B	irth(MM/DD/Y	YYY) 9. Bir	thplace (State or
Director		608-60-4596	1 X M 2 F	17	Yrs.	Months Da	ays Hours	Min. 07/15	/1990	Foreig Co	thplace (State or California untry)
	,	Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City, Town	or Locatio	2			1.		404 1-14- 69-15-16
1 00 W R										:	10d. Inside City Limits  1 Yes 2 No
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ith th 23a 23a	a	3548 Chateau  11. Marital Status	12. Was Decede	-15	1 40 101		.631			USA	
ath w items	<b>Funeral Director</b>	1 X Never Married 2	Aarried Armed Force	s?	13. Was	Decedent of F , specify Cuba	nspanic Origir an, Mexican, F	n? ( Specify Yes or N Puerto Rican, etc.)		Race - Ameri Vhite, etc.	can Indian, Black,
fter de I", or		3 Widowed 4 Di	1 Yes	2 X No	1 X \	'es 2 N	lo specific F	uerto Ric	On See	w Uia	oomie
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5-00 iled with Hygien I other	To Be Co	17. Father's Name (First, Middle	e, Last)				18.Mother's	Name (First, Middle,			<del></del>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		Andres Perez,	Sr.		- 21		Kell	y Lynn Sir	nmons		
D 21215-003 should be filed withing and Mental Hygienc. 7 is marked other the		19a. Informant's Name/Relation						er or Rural Route Nu			
re, MD 21215-0036 s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho er traumatic event, the Medical Examiner must be notified at once.		Andres Perez, 20a. Method of Disposition	Sr./Father	1 20h Place	of Dienociti	on (Namo of a	ometer.	East New M	larket,	MD 2:	1631
Baltimore, MD 21215-0036  semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Pepartner of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she ujury or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Crematic	n 3 Removal from	State Quicremat	ory or othe	r place)	emetery,	8/2/2007	200. Local	on - City or	Town, State
timent rtant:		4 Donation 5 Other S		Good	Couns	ėl Cem	etery	3/2/2007	Secre	etary,	MD
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum		21 Signature of Fun fall Service	Licensee	11000	Cur	ran-Br	ss of Facility OMWELL	Funeral H ambridge,	Home, I	.A.	
Physician		23a Part I. Enter the disease, of	r complications that cause	ed the death. Do no	1 308	High :	St., Co	ambridge,	MD 216	13	Approximate taken of
/Medical		failure. List only one cause	e on each line.		one inc	mode or dying	g, such as can	and or respiratory ar	rest, snock, or	пеап	Approximate Interval Between Onset and
Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injurie  Due to (or as a con				_				Death
		Sequentially list conditions,	b								
		if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause									
41/4		(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):				<del></del>			
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit			d								
o, o, e be exe	dica	UNPENDED	AMENDED					<u> </u>			
760 icate i	n/Medical	IF FEMALE: 23b. Was decedent pregnant in t		ome of pregnancy					23d. Dat	e of delivery	
certif	ian	past 12 months?	1 Live birth	-111	Fetal		Ectopic p	regnancy	Mont	h D	ay Year
30x death	Physicia	1 Yes 2 No 9 Un	known 9 Unknown	at time or death 5	Othe	(Specify)					
that the death certificate by the attending detached for use as		Part II. Other significant condi	tions contributing to dea	ath but not resulting	g in the und	erlying cause	given in Part	I. 23e. Did t	obacco use co	ontribute to t	the cause of death?
signed	d by							1 Ye	s 2 No	3 Prob	ably 4 🗸 Unknown
ords, w requires been should	lete							24a. Was			topsy findings available
eco he law te has	Completed	-							rmed?	death?	ompletion of cause of
	ပို	25. Was case referred to medica				26.Plac	e of Death (C	neck only one)	2No	1 🗸 Yes	s 2 No
Vita hysicia this ce	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2 ✔ ER/Ou	utpatient 3		IOthor:	lursing Home 5	Residence	6 Other:	
	1	27. Manner of Death	28a. Date of In	jury 28b. 1	Time of Inju	ry 28c. Inju	ury at Work?	28d. Describe		curred	-
	ertification:	Natural 5 Pen 2 Accident Inve		2150	hrs	1	Yes 2 🗸 N	Subject mo	torcyclist i	n motor v	ehicle accident
ViS or At fiter d Direct in by	ij		stigation 28e. Place of	Injury - At home, fa	rm, street,	actory, office	building, etc.	28f. Location (	Street and Nu	mber or Rur	al Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Sel	4 Homicide	rmined (Specify) M	ajor Road / Hi	ghway			or Town, S Md. Rt.589, B	erlin, Md.		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one) Certifying P	hysician: To the best of r miner:On the basis of ex	ny knowledge, dea	th occurred	at the time, d	late and place	, and due to the caus	e(s) and man	ner as state	d.
To t	Medical	29b. Signature and title of certific	and manner stated	l.	ivestigation			red at the time, date			
		200. Organization and the or certific	11 -11	/>		29c. Licens		ME			th, Day, Year)
		1 herely	Me Fy	JTh, ~	w	J 0.C.	. IVI. L.		July 28,	2007	
2		<ol> <li>Name and address of person Theodore M. King, Jr.</li> </ol>		death (Item 23a) Medical Exami	ner 1	I1 Penn St	reet. Baltir	nore, MD 2120	1		
St		31. Date filed (Month, Day, Year)		ar's Signature	1 4						
Regist	rar	AUG 0 7	2007 Selection	15. Fg	male		· · -				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2ABETH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥍 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Midgle, Month **Physician** cters ster /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner S DU 11 nchorag ursina It Under 24 Mrs If Under 1 Year Birthplace (State or Foreign Country) iat Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 100M 200 **Funeral** Days 230-50-4//5 Usual Residence of Decedent Yrs 8-3-40 Director 10c. City, Town or Location filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Be Completed by Funeral Director 1comic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT 101 21802 USA ROAD 1012-EAST Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian. or iteme 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 ☐Widowed 4 ☐Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) TRUCK 12 RIVER other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Hy importent: If Item 27 is marked oth eny injury or other treumatic event once. 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be HARMON DIS KOBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PRINCESS ANNE MD 21853 POLKS RD 28611 PETERS~BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) ALISBURY DREEN RE 26. Signature of Funeral Service Licensee BENNIE Jord MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician RENAL FAILURE /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physicien and I be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Dinknown 1 ☐ Yes 2 ☐ No page 2 should 24a. Was an autopsy performed 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete 1 Yes 2 No director, 25. Was case reterred to medical examiner? 26. Place of Death (Check only one, Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 WNatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) To the Hospital or At within 24 hours efter of To the Funeral Direct 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D6343 MD

State Registrar

DHMH 17 Rev 1/2001

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JU17 504 B

MD

SAUSBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOSHI

5

31. Date tiled (Month, Day, Year)

106 MILFORD ST

32. Registrar's Signature

Uplus

07-05701 Russell Reid

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

tossell i tela	F	1- For State Crivial yiand / Department of Fleath and Weine Registrar Certificate of Death	Re	g. No. 201	17 2532
Physicia	-	1. Decedent's Name (First, Middle,Last)	Date of Death     Month	Day Year	3. Time of Death 1459 hrs
Medical Examin		Russell Reid	July 24, 20	07 4c. County of Dea	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of University Hospital  Baltimore	Death	4c. County of Dea	u i
	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under	24Hrs 8 Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or
Funeral Director		Months Days Hours.	Min	Fore	ign
Birestor	-	217-13-3285   1X M 2 F   36 Yrs.	April	2,1971°	Wash.,DC
S S S S S S S S S S S S S S S S S S S		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits
<b>*</b>	. 1	Md. PG Mitchellville			1 X Yes 2 No
daryland 28n-f show	황	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
or 28	<u>=</u>	10209 Tulip Tree Drive 20721	11	nited St	atos
vith th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin			erican Indian, Black,
eath vitem	Fune	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	White, etc.	
ifter d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	•	Specify: Bl	ack
atura	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind and the completed)  16b. Decedent's Usual Occupation (Give kind and the completed)		16b. Kind of Business	s/Industry
6 72 h	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	iso rollios)		
yithir withir iene er th	Completed	12 Entrepreneur	Name (First, Middle, N	Private	
215-0036 be filed within 7 ntal Hygiene rked ofter than ent, the Medica			y White	iaiden Surname)	
D 21215-C should be filed v and Mental Hygi 7 is marked oth	o Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Numb		ber, City or Town, Sta	te. Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Menial Hygiene mit. If item 37 is marked other than "matural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	۴Į	Peggy Reid/mother 108 Dauntly Str		•	, , ,
and 2 lealth tem 2 traus		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
lore ges 1 it of F it If i		1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Departing 5 Other Specific Resurrection Cem. 7	7/21/07	Clinton	ма
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	4 Donation 5 Other Specify: RESULTECTION Cells. 1 21 Signature of Funeral Service Licensee 22. Name and Address of Facility		Clinton	
Baltimore, ML permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traums.		CAMICE Educator 3910 Silver I			
Physician	-	234. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical		✓ailure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of Gunshot Wounds	•		Death Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b.			1
	ine	if any, leading to immediate Due to (or as a consequence of):			S
123	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	- · <del></del>		
cecute r		d			
60, ate be exe oblysician a	Medical	UNPENDED			
760, icate be physici the buri		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	,
68 certif nding ise as	Įį.	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month	Day Year
Box 687  Re death certifice  The attending part of for use as ill	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. Box 687 that the death certifined by the attending detached for use as t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I. 23e. Did to	bacco use contribute	to the cause of death?
ires that signed to the deta	Completed by		1Yes	2 No 3 P	robably 4 Unknown
rds requir	ete		24a. Was autop		autopsy findings available o completion of cause of
e law e has	E G			med? death	?
H. Th	ပို	25. Was case referred to medical 26.Place of Death (i			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	9 B	examiner? Uses tell	Nursing Home 5	Residence 6 Ott	ner:
of \officers		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		now injury occurred	
on endin ath. or: A	힐	1 Natural 5 Pending Apr 22, 2006 0243 hrs 1 Yes 2 ✔	No Subject sho	ι	
ivisior or Attendafter death Director:	ijca Liga	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc	28f. Location (S or Town, S		Rural Route Number, City
Divoltal of ours at Divilled i	Certification:	4 Momicide determined (Specify) Parking Lot	13501 Baltimo	ore Ave, Laurel, MD	)
Hosp 24 hc Fundetely in	ä	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only)	ce, and due to the caus	e(s) and manner as si	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Ariending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occarding and manner stated.	curred at the time, date		
	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	Month, Day, Year)
		Mhua Geasse 4 M2 O.C.M.E.		July 26, 2007	
,		30. Name and address of person who completed cause of death (Item 23a)	ND 04004		
1		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, NID 27207		
	ate				
Regist	ueii				

Registrar DHMH 17 Rev 1/2001

State

Revathy Murthy MD,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

1.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Stefan Ryan Robert /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Ye 6/2/1956 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours Min ¥134 M 2□ F 51 Yrs. 217-66-0260 Germany Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Important: If flem 27 is marked other than "natural", or flems 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2 No Maryland Prince George Lanham Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9512 Sheridan St. 20706 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3altimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Robert Elementary/Secondary (0-12) College (1-4or 5+) Field Supervisor Showcase Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f Zandt Theresia Duschinsky George ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RYAN, Theresia Heflin/Mother 9512 Sheridan St. Lanham, Md. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 7/27/2007 Clinton, Maryland 4 □Donation 22. Name and Address of Facility 21. Signature Juneral Service Licenses George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician immuno /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be det Be Completed by TESSICATORU nknown 2 No 3 Probably アッセノハックワイカ 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 hipatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Date of Injury 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident hours after death uneral Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WELTZ 7525 6:200 000

32. Registrar's Signature

		•	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of I			eg. Nó	07	25023
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia		Lucille	W.		Sturgis		7	25	2007	4:25 AM
	/Medic Examin		4a. Facility Name (If not institution, give st.				r Location of Death		4c. Coun	ty of Death	
	Examin	eı				Berli	n		Wor	cestei	
			Atlantic General Ho 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birtho	lace (State or Foreign
	Funeral		1□	M 2∏F	Yrs	Months Days	Hours Min.	(Month, Day 8-17-19	, Yea <i>r)</i> 11.2	Vir	ginia
	Director	-	224-28-8209 Usuel Residence of Decedent		94		1	0-1/-12	/12	VII	511114
1	. A		10a. State 10b. County		10c. City, Town or Lo	cation					0d. Inside City Limits
	a h	ō	100		Caliaburr						1 ☐ Yes 2X No
	288-	Director	MD Wicomico  10e. Street and Number		Salisbury	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	De d						1		USA		•
-	oeath with the maryland ms 23a or 28a-f show must be notified at	Funeral	423 Virginia Avenu	2. Was Decedent		2180		acify Vas or No-		ace - Ameri	can Indian
	te de	une	11. Marital States	Armed Forces?		If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	В	lack, White,	
g ·	or i	by F	1 Never Married 2 Married	1 ☐ Yes 2 🕅 1 If Yes, Give	10	1 ☐ Yes 2💆 No	Specify:		Spec	oity: Whi	lte
Ś	nours after tural', or ite		3 ₩idowed 4 Divorced	Year or Dates:	1 40- P	death Herel Occur	ti-n	· · · · · · · · · · · · · · · · · · ·	16b. Kind of	Business/In	dustor
9500-61717	nat nat	ete	15. Decedent's Educ (Specify only highest grade	tion completed)	(Give	dent's Usual Occup kind of work done	during most of work d)	king	IOD. KING OF	Dusinosarii	dustry
7	within 72 ene. than "nai he Medic	dп	Elementary/Secondary (0-12)	College (1-4or 5	+)				Flori	ct	
	Hygier Hygier Sther th	Completed	10		Owner	/Operator	18. Mother's Nam	o (Eiret Middle			
Maryiand	be lied within 72 hours after death with the waryan lat Hygiene. Id Hygiene. d other then "natural", or Items 23a or 28a-1 show svent, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)					,			
<u>la</u>		ဥ	William Festus Wat	son			Mary Est				
a L	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ	e, Print)		_	and Number or Ru				o Code)
	and and a salth in 27 i		Talbot E. Sturgis,	Jr so			, Windson				
ย์	f He itsm		20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Locatio	n - City or T	own, State
2	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Springhil			0-2007	Hebron	, Mar	yland
			21. Signature of Fugeral Service License	3 1 1		2. Name and Addre		Bounds F	uneral	Home	
ğ	permit Depart Import any in		Melisa Heun	Plabo	7	OF E Mad	in Street				nd 21804
			23a. Bart1. Enter the disease, or complice	ations that caused	I the death Do not en	ter the mode of dvi	no such as cardiac	or respiratory ar	rest.	aryia	Approximate
			shock, or heart failure. List only on	causeon each li	ne. / /	1 5	= /	. ,			Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	One	cotive N	tet.	Cellane				Moules
	/Medical Examiner		resulting in death)	Due to (or a	a consequence of):	1	0-				Moures
١,	- Xaiiiiiei		Sequentially list conditions,	Core	ney 17	tre	101 >48	<u> </u>			
	p =	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cons - uence of):						
	cute nd rans	аш	that initiated events c							-	
o T	a∩a ana uriat-t		resulting in death) Last	Due to (or as	a consequence of):						
8760	cate be executed physician and the burial-transit	dicai	d							_	
89	tifica ig ph as th	0									
Вох	andir use	Ş	23b. was decedent pregnant	sc. If yes, outcome		□Ectopic pregnand	ev.			Date of deliv	*
m	d for	cia	in the past 12 months? 1 Yes 2 No	4☐Pregnant a	_	Other (specify)				Month	Day Year
o.	the y the	ys	9 ☐ Unknown	9□ Unknown				-			
م	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/M	Part II. Other significant conditions con	tributing to death t	out not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?
Vital Records,	sign d be	Q P						1 🗆 '	res 2□No	3   Pro	bably 4 <b>K</b> nknown
ក្ល	been show	Completed						24a. Was	an 24	h Were au	opsy findings available
e e	law nasl	du						auto		prior to c death?	ompletion of cause of
	The sate	Ö						1 ☐ Yes	No _	1 ☐ Yes	2 No
Ħ	stan: ertific ctor,	Be	25. Was case referred to medical examiner?			I a		ath (Check only o	nel		
~	ysic dire	ို	1 ☐ Yes 2 D No		ent 2 <b>ER</b> /Outpatie	III JUDON		lome 5 Resi			ify)
0	ing PI ter th		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) 1njury	of 28c. Inju	iry at ork?	28d. Describe	how injury oc	curred	
Division of	ath. r: Af	atic	2 Accident investigation			M 1	Yes 2□No				
<u>s</u>	Atta scto by th	ij.	3 ☐ Suicide 6 ☐ Could not be determined		jury - At home, farm, s	treet, factory, office		28f. Location ( City or To		ımber or Ru	ral Route Number,
á	afte Dir d in	Certification:	4 I Homedo	Dulldary, 6	ic. (Openy)				,,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge, dea	th occurred at the t	time, date and place	and due to the	cause(s) and	manner as	stated.
	B Hd 24 l Fu letely	edicai	(Check only 2 Medical Examinations)	er: On the basis of and manner s	of examination and/or it ated.	nvestigation, in my	opinion, death occu	urred at the time,	uate and plac	ы, апо дие	to trie catise(s)
	of thin	₹	29b. Signatore and title of certifier			29c. Licer	nse number		29d. Date sig	hed (Month	Day, Year)
)	- 3 - 3		V// The Wille	h	1	T)	2876	7	7/	251	07
,	18		11/1/08		doub (Ita = 200) (T	Print)	,				- /
1	10		W. Name and address of person who co	inpleted cause of	death (Item 23a) (Type	9 Court	Ille.	- Ex.	ret I	cle.	De 1994
		1	1 0000 Ver 1-0000	me / c	~ ~ ~	, —		7	•	/	
		ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		· ·	,		•	

DHMH 17 Rev 1/2001

PUB-08/17/1906

Lucille Storgis 224-28-8209

ORIGINAL

07-05505 James David Spell

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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1			
-	500 I	-	4 Lm -

		For State			Certific	ate of	Death					eg. No.			
Physiciar edical Examin	n/ <sup>1</sup> er	Decedent's Name (First, Middle James Day	vid S	pell							Date of Dea Month July 18, 2	007 	Year	3. Time of Death 0556 hrs	
	4	a. Facility Name (if not institution Prince Georges Hospit			_	41	b. City, Tow Chever		cation of I	Death		Princ	inty of De ce Geor	ge's	
Funeral Director		5. Social Security Number 216–19–9189	6. Sex		(In yrs. last bit	rthday) Yrs.	If Under	1 Year Days	If Under:	24Hrs. Min.	8. Date of Bi		For	Birthplace (State or eign Country) Wash.	DC
2 hours after death with "natural", or Items 23.	eted by Funeral Director	10e. Street and Number 1110 Iago Ave  11. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Div.  15. Decedent's Education (Special	12. W A Irried A I I Orced If Yes, or Date	/as Decedent rmed Forces? Yes 2 Give Year os:	X No	13. Was If Ye	10f. Zip C  10f. Zip C  s Decedent es, specify (  Yes 2 X  's Usual Ocust of work)	ode 207 of Hispo Cuban, No ccupation	anic Origin Mexican, F specify: on (Give ki	Puerto Ri	sify Yes or N can, etc.)	Spe	SA Race - An White, etc cify:	nerican Indian, Black	X No
21215-0036 Auld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Compl	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, David Wald	_	ell, Jı			elf Em	18	3.Mother's	eri	Marie	Maiden Sur	name)	Contract	or
Baltimore, MD 212 bernit. Pages I and 2 should b Department of Health and Meni Important: If item 27 is marl injury or other traumatic eve	₽[	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Si  21. Signature of Funeral Service	(sign	ificant	20b. Place	e of Dispos latory or oth Crem	10 Ia ition (Name ner place) natory lame and A	go and a second	Avenuetery, of Facility	ue ( July 200 Le	Capito Date 22 07 Funer	l Heig 20c. Loca Cli	shts, ation - City nton ne Ca	y or Town, State	
Physician /Medical .xaminer		23a. Pan I. Enter the disease failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line a. Multi	ns that caused e. ple Injuries o (or as a conse						_				Approximate Between Ons Death	Interval set and
vecuted 1 and - transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conso											
x 68760, h certificate be er rending physician use as the burial	ysician/		230 1 230 1 24 2 known g	Unknown	time of death	2 Fe	etal death ther (Speci	ify)				Мо	Pate of del	Day Ye	ear
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ial Rec ian: The la certificate h	Be Col	25. Was case referred to medic examiner?		ali, mai	F				of Death	-	nly one)				
n of Vita ding Physicia After this cer funeral direct	၉	1 Yes 2 No  27. Manner of Death	2	al: 1 Inpati 8a. Date of Inj Jul 18, 2007	ury 28	R/Outpatien Bb. Time of 000 hrs		8c. Injui	y at Work ′es 2 ✔	?		Residence be how injury storcycle a	occurred	Other:	
Division of Vital Records, vitual Records, within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	2 Accident Involved 3 Suicide 6 Counciede 4 Homicide	estigation ald not be ermined	28e. Place of I	ajor Road /	Highwa	y			2	or Town 22700 Bloc	n, State) k Aquasco	Road, ,	or Rural Route Numb	per, City
To the tlost within 24 ho To the Fun completely f	Medical C	29a. Certifier 1 Certifying I Certifying I Medical Ex	aminer:On t	o the best of n he basis of exa manner stated	amination and/	death occu	ation, in my	opinion	ete and pla , death oc e number	ace, and curred at	due to the c	ate and place	, and due	s stated. to the cause(s)  (Month, Day, Year)	
		Ocema M 30. Name and address of person				Ba)		O.C.				July 1	9, 2007	7	<u></u>
0	-aka	Donna M. Vincenti, N	1D Ass	istant Med		ner 11	1 Penn S	Street	Baltim	ore, M	D 21201				
Regis	tate trar	JUL 2 4	2007	Benero	19	boa	er.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 22, Year **Physician** Marie Springmann 12:05 P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 3, 1909 9. Birthplace (State or Foreign Country) Washington,DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months 579-64-7603 98 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ıral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Silver Spring Maryland Montgomery Direct 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 3330 N. Leisure World Blvd. #219 20906 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental Charles Springmann Elizabeth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. W. Warren Taltavull/Cousin 3330 N. Leisure World Blvd. #219 Silver Spring, Md. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 7/25/2007 4 Donation 5 Dother (Specify) Washington, D.C. Funeral Service Licens 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland als 23a. Part1. Enter the disease, or complications that/daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hertensive CondioVas Culon Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of) Examiner Gays many list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examiner law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown ts been signed by t. 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 or Attending Physician: The death? 1 ☐Yes certificate 1∐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4KNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXXNo 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation XX Natural Injury 1 ☐ Yes 2 ☐ No hours after death. uneral Director: A death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Medical 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 24 one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier

State Registrar

32. Registrar's Signature S. Spice

Rakesh Arora, M.D. 14300 Gallant Fox Lane Suite 222 Bowie, Md. 20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar			Cer	fificate of	Death		Reg. N	2 1 1 7	2533.
	Physicia	20	1. Decedent's Name (First, Middle, La	*					2. Date of De Month	eath	Day Year	3. Time of Death
	/Medic		Raymond Charl		ard				July	23	2007	12A M
	Examin	er	4a. Facility Name (If not institution, give					or Location of Death		4	c. County of De	
			Calvert Memor  5. Social Security Number 6. S		Ltal (In yrs. last b		Prince If Under 1 Year	Frederi		i mello.	Calve	
	Funeral Director			M 2□F 7. Age	66	Yrs.	Months Days	Hours Min.	(Month, D	av. Yea	1940 P	irthplace (State or Foreign Country) ennsylvania
	/land ow at		10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	a-f sh ified	tor	Maryland Calve	rt	Prin	ice :	Frederi	lck				1 □Yes 2 <b>□K</b> No
	or 28	Director	10e. Street and Number				10f. Zip Code	·		10g. C	Citizen of What C	Country?
	ath w	ral	1665 Mallard Po	oint Road	<u> </u>		20678				ited S	tates
	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - Arr Black, Wh	
2-003p	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. If health and Mentel Hygiene. To is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	° 58–	-62 1	□Yes 2√2 No	Specify:			Specify: w	hite
<u> </u>	n 72 h "natu edica	Completed	15. Decedent's Ec (Specify only highest gra	lucation ide completed)		a. Decede	ent's Usual Occup ind of work done	pation during most of wor ed)	king	16b.	Kind of Busines	s/Industry
7	within than the Man	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	· I					<sub>EP</sub> .	levato:	-a
alla	other rent, i	Be C	17. Father's Name (First, Middle, Last,			iper.	intende	18. Mother's Nan		e, Maide	en Surname)	
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Dall	permit. Departr Imports any Inju		21. Signature of Funeral Service Licer	isee			Name and Addre	Ra			al Home	
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	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			1 C 2 A	2:1001/-		4			Interval Between Onset and Death
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	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dualto (or as s	consequence	of):						
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DOY.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐Fetal dea		Ectopic pregnanc Other (specify) _	у			23d. Date of d Month	elivery Day Year
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ב	The page	Con							perf 1□ Yes	ormed?	death?	,
	cian; sertific ector,	Be	25. Was case referred to medical examiner?	II No.				26. Place of Dea	th (Check only	one)		
5	Phys this al dir	P.	1 ☐ Yes 2 ☐ ¥60	Hospital: 1 ☐ Inpatier 28a. Date of Injury			3 DOA				6 □Other (Sp	ecify)
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5	al Olic	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)				City or To	wn, Sta	ite)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 ☐ Certifying Ph (Check only one)	ysiclan: To the best on nIner: On the basis of and manner state	examination a	ge, death and/or inv	occurred at the ti estigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time	e cause e, date a	(s) and manner a and place, and di	as stated. ue to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	,			29c. Licens			29d. D	Date signed (Mor	nth, Day, Year)
			Chill We	EN NO			720	0358		于	14 2	22005
2	3+1		30. Name and address of person who	completed cause of de	eath (Item 23a	) (Type, P	rint)	035P = FROI	FRIC K		91- =	10678
E	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	arki	(-(,	11		. /	(1)	3010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 15, 2007 Navada Loretta Tingle 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10504 Flower Street Berlin Worcester If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 K Yrs. Director 222-30-3463 58 Jan. 6, 1949 Maryland Usual Residence of Decedent death with the Manyland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo **Funeral Director** MDWorcester Berlin 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10504 Flower Street, Apt. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or iter any injury or other traumatic event, the Medical Examinat ODES. Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Berlin Nursing & Elementary/Secondary (0-12) College (1-4or 5+) 8th Laborer Rehabilitation Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Melvin Williams Ella Mae Tingle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Flower Street, Apt. 8 - Berlin, Maryland 21811 Leslie Tingle/Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Curtis UMC Cemetery July 21, 07 Bishopville, MD 21813 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1213JerseyRoad 21. Signature of Funeral Service Licensee Jolley Memorial Chapel, P.A. - Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causeyon each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Wast **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ed by the ettending physicien detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 QUoknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete 1 Yes 2 No efter death.

Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ၀ 27. Manner of Death 1 Natural 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ŝ 29b. Signature a 29d. Date signed (Month, Dey, Year) 0 25 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) MRROLL ST SAUSKURY RUSSO 145 080 h 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 2 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05783 State of Maryland / Department of Health and Mental Hygiene Brenda Tucker Certificate of Death Rea. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 28, 2007 0825 hrs Brenda Tucker Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) 05-24-1962 VΑ 1 M 2 X F 45 216-84-0569 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County X Yes 2 No 28a-f show Chesapeake Beach is 23a or 28a-f show MD Calvert Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number IISA 20732 8205 Harrison Boulevard 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) is marked other than "natural", or items event, the Medical Examiner must be White, etc. Armed Forces? Never Married 2 X Married vermit. Pages 1 and 2 should be filed within 72 hours after dea. Popartnent of Health and Mental Hygiene. portant: If item 27 is marked or ury or other train... Yes 2 X No f Yes, Give Year Yes 2 X No specify: Specify: white 3 Widowed Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) own home homemaker 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ollie Marie Collier æ Billy Joe Frazier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 8205 Harrison Blvd., Chesapeake Beach, MD 20732 Linda M. Doyle, sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State 1 X Burial 2 Cremation 3 08-02-07 Suitland, MD Wash. National Cem. Donation 5 Other Specify 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee Harmony Lane, Owings, MD 20736 8325 Mt. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death Cardiac Arrythmia Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit X UNPENDED AMENDED ed by the attending physician detached for use as the burial Items: 23a & 27 per MEO G-872 10/19/07 reb Physician/Medi the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ģ Yes 2 V No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a, Was an certificate has been autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> examiner? Hospital: 1 Other 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient this 1 Yes No After the 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No 24 hours after death. Director: d in by the f Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) within 24 hour.
To the Funeral Di (Specify) Homicid 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 29, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD.

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9	72 hours after death with the Maryland natural; or tems 23a or 28a-f show alcal Examber most be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie		No		Was Decedent of H f Yes, specify Cubin 1 ☐ Yes 2 元 No	lispanic Orig an, Mexican Specify:	gin? (Specify i, Puerto Rica	Yes or No- in, etc.)		. Race - Amer Black, White pecify: W	, etc.
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Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.	To Be C	17. Father's Name (First, Middle, L Amos Orlando W						ar's Name <i>(Fi</i> 1a Ash		Maiden S	umame)	
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Baltimore,	of He of He If item		20a. Method of Disposition  14 Burial 2 ☐ Cremation	3 □Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pla	сө)	Ju1y Date		20c. Loca	tion - City or	Town, State
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William H. Wolfe July 20, 2007 9:40 A M \*\*/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing & Rehab Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 74 Director 578-44-5008 4/13/1933 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f sh notified 1√TYes 2 No Director MD Rockville Montgomery 10f. Zin Code 10e. Street and Number 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be in 641 Lincoln St. 20850 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 No If Yes, Give Year or Dates: 53-55 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21X No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Grocery Clerk Food marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any Infury or other traumatic event 17. Father's Name (First, Middle, Last) Be Helen Grey Calvin Wolfe ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4020 Patriot Rd., Amsterdam, OH 43903 Teresa M. Blotner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/2007 Brentwood, MD Ft. Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln F. H. 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ulmonav /Medical Due to (or as a consequence of): Examiner sequentially list on filling if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy perform 2 KNo 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No r 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 X Natural
2 ☐ Accident Injury 5 Pending investigation To the Husping after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062435

State Registrar

DHMH 17 Rev 1/2001

2 4 2007

DHYED

31. Date filed (Month, Day, Year)

971 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHYYHO

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Rockutte, MD 20850

			For State Registrar	State of Marylan		artmen rtificat				giene Reg. No.	107	25337
	de l		Decedent's Name (First, Middle, Last	st)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	_	Leonard	Eugene	Will	iams				20 20		2:48 P M
	Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of Dea	th		nty of Death	_
d.		W	Prince George's				iever	-				George's
	Funeral		5. Social Security Number 6. S	DM aDE	last birthday) Yrs.	Months	1 Year Days	If Under 24 Hrs Hours Min		th y, Year)	9. Birth	place (State or Foreign intry) DESSEE
4	Director		410-58-4089 Usual Residence of Decedent	68					Jan 29	1939	Tem	lessee
	land		10a, State 10b, County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Man a-f sh	ţċ	Md Prince	George's M	itchel	lvil	Le					1 X Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen	of What Cou	untry?
	4 within 72 hours after death with the Maryland Jiene r than "natural", or items 23a or 28e-f show The Madical Examinat runt be mulified at		11605 Marjorie D	rive				20721		U.S.		
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		Race - Amer Black, White	
9	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 🗌 Yes	2 <b>X</b> IO	Specify:		Spe	cify:	<b>Black</b>
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-	be filed stat Hygi od other event.	Вес	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle	, Maiden Sun	iame)	
yiand	ould be I Mental I varked o	ToE	Richard William	S				Mildr	ed White			
Mar	es 1 and 2 should by the and Ment of Health and Ment Illem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address	(Street a	and Number or F	Rural Route Numb	er, City or To	wn, State, Zi	ip Code)
	and sealth m 27		Mary E. Williams/	Wife	11605	Mar	orie	Drive	Mitchell Date	ville,	Mary.	land 20721
o e	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		emetery, crei	matory or	me or other plac	ce)	Date	20c. Locatio	on - City or T	rown, State
Baltimore,	permit. Pages Department of I Important: If Ite any injury or o'		4 □Donation 5 □ Other (Specification)									Virginia
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):		\	-				
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8/60	cate be executed physician and the burial-transit	dicai		Gastron	utes t	~~~	13	1000	9			
9	artifica ing pi	Med	IF FEMALE:									
. Box	eath certifi attending   I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta	death 3	Ectopic p		1		23d.	Date of deli- Month	very Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5L	Other (s	оеспу)					
1	The law requires that the death certifithe has been signed by the attending rage 2 should be detached for use as		Part II. Other significant conditions of	contributing to death but not res	ulting in the u	inderlying	cause giv	en in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?
g	uires tha signed Id be de	d by							150	Yes 2□N	o 3 □ Pro	obably 4 Unknown
Ö	w require been si	Completed							24a. Was	an 24	4b. Were au	lopsy findings available
æ	he tav e has age 2	mc								ormed?	prior to death? 1 ☐ Yes	completion of cause of 2 <sup>20</sup> No
ē	ician: Th certificate rector, pag	Be C	25. Was case referred to medical		*	-		26. Place of D	1 ☐ Yes eath (Check only	2 No	1 162	263110
Division of Vital Records,	S D	0	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 Nnpatient 2	ER/Outpatie	nt 3 D	OA Dth	000	Home 5 ☐ Res		Other (Spec	cify)
5	ding Phone	T :U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injur Wor	y at rk?	28d Describe	how injury oc	curred	
<u>o</u>	Attending r death.	atio	1 Natural 5 Pending 2 Accident investigatio	n		М		Yes 2 □No				
<u> </u>	or Attendated attendated Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, st	reet, factor	y, office		28f. Location City or To	(Street and Ni wn, State)	umber or Ru	ıral Route Number,
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	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exer	hysician: To the best of my knominer: On the basis of examination and manner stated.	wiedge, deat ition and/or in	th occurred rvestigation	at the tir n, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and date and pla	manner as ce, and due	to the cause(s)
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	F X F 8		m. Thole	V.		Z	000	54981		7/20	107	- A
•	(2)		30. Name and address of person who	completed cause of death (Item	n 23a) (Tvoa							
- 1	9		30. Name and address of person who Mukemil F. Abdel	lla M.D. 6005 I	andove	er Ro	ad S	uite 3 (	Cheverly,	Maryl	and 2	08/5
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign								
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DHMH 17 Rev 1/2001

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	. 3		Registrar  1. Decedent's Name (First, Middle, Last)			Death		Date of Death	J. No	1 /	3. Time of Death
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	and w t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation			-		1	0d. Inside City Limits
	Maryl -f sho fled at	tor	Maryland Baltimore	Baltim	ore Count	·V					1 □Yes XXNo
1	or 28s	Oirec	10e. Street and Number		10f. Zip Code			100	j. Citizen of V	Vhat Cour	itry?
	s 23a nust b	eral [	8810- Walther Blvd. Apt. 20			21234	0.40		USA		- 1- 4"
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent E-Armed Forces?  13. Was Decedent E-Armed Forces?  14. Was Decedent E-Armed Forces?  15. Was Decedent E-Armed Forces?	7er in U.S. 13	If Yes, specify Cub		1? (Specity Puerto Rica	Yes or No- an, etc.)	Blac	e - Americ k, White,	etc.
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3	marke	우	Elmer Ager  19a. Informant's Name/Relationship (Type. Print)	19h Mai	iling Address (Street		cy Wi		City or Town	State 7ir	Code)
<u>8</u>	ind 2 salth ar 27 is ar trau		Wm. C. Ager (Son)	1	12 Winter						5 <b>~</b> 7455
ກົ່	of Her	1	20a. Method of Disposition  X1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disp cemetery, cr	position (Name of rematory or other pla	ice)	Date	20	c. Location -	City or To	own, State
	t. Pag ntment ntant: I	ŀ	4 ☐ Donation 5 ☐ Other (Specify)		View Cem		-7-20		ristol		
ם מ	Depar Impor any Ir		21. Signature of Funeral Service Licensee		22. Name and Addre 7401 Bela			ahn Fur imore.			
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5	The law requires that the death certificate has been signed by the attending loage 2 should be detached for use as	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Unknown		Other (specify)				Mic	onth	Day Year
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necorus,	equires en sig	ed by	Aremia CUA	<del>*</del>	TN		_	1 ☐ Yes	2 🗆 No	3∐ Prob	pably 4 Unknown
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VIIal	n: The ficate I r, pag		07 W					perform 1□ Yes 2	No	death? 1 🗌 Yes	2□ No
=	Physician: r this certifica ral director, I	To Be	25. Was case referred medical examiner?  1 Yes 2 No Hospital: 1 Inpatien	nt 2 ☐ ER/Outpati	ent 3 DOA Ott	hor:		5 Residen		er (Snecii	
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	F 3 F 8		29b. Signature and title of certifier		7	T311	5	1	1	3/	2007
n	OX1		30. Name and address of person who completed cause of de			1.	6	21:2	.,		0.001
d			31. Date filed (Month, Day, Year) 32. Registra	r's Signature	id Park.	ville 1	M	2123	7		
	Sta Registr		AUG 0 8 2007	rs Signature	foll						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Martha C. Ambrose 4:40 PM 4c. County of Deat /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Sinzi Hospither 152/timore If Under 24 8. Date of Birth (Month, Day, 12-30-1920 5. Social Security Number 6. Se Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min Year) 1 □ M 2 🛛 F 86 165-18-1766 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Pennsylvania Pottsville Schuylkill 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17901 5 South Jackson Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Convenience Store Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, th once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Maracani, Sr. Marv Petruzzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Ambrose - Son 1704 Mahantongo Street Pottsville, PA 17901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Calvary Cemetery 08/10/2007 Pottsville, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sofrice Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 16mes 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) utra-cevebral **Physician** day 5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□ Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has perform certificate 1 TYes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident death. within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

be executed Box 68760. requires that the death certificate Ö σ. Division or Vital Records, To the Hospital or Attending Physician:

> 10 Registrar

31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifie

Begistrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

29c. License number D63298 29d. Date signed (Month, Day, Year)

6,2007

**ORIGINAL** 

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		Registrar     Decedent's Name (First, Middle)	le, Last)			inoate of I	Jean	2. Date of D			3. Time of Death
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Funeral Director		5. Social Security Number 217-62-3416	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	2 Yrs.	Months Days	Hours Min		ay, Year)	Cou	nplace <i>(State or Foreign</i> <i>Intry)</i> ARYLAND
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2 shou and N is mai	1	19a. Informant's Name/Relations	ship (Type. Print)			g Address (Street					
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11		30. Name and address of person DR AL-ABBA	who completed cau	se of death (Iter		Print) . INK IN SQU	vale ben	ic Balhi	nois 1	mary lan	21237
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faryland		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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DESILLINOR permit. Pages Department of Important: If It any injury or o			s Cem. 8/7/2007	Dundalk, Maryland
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To t To t	2	296. Signature and title of certifier  29c. License r	1 Q 79	29d. Date signed (Month, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	) Ra Sta	100 Colou Brenia
	State istrar			The Johnson

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 19USt 2007 Bobby Boyd Bateman, Sr. /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9 oseda vare 7 Age (In vrs. last 8. Date of Birth (Month, Day, Year) 04/15/1933 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number If Under 1 **Funeral** 1**X** M 2□ F 74 Director 241-46-6995 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Kingsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Funeral U.S.A. 6808 Mt. Vista Road 21087 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 1954 - Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) - American Indian. "natural", or items 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins than " Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene Department of Health and Mental Hygiene Important: If item 27 is marked other that any fijury or other traumatic event, the Lone. Grounds Supervisor University 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard William Bateman Maude Savanna Wilhide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Bateman (son) Chain O Hills Road - Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Ø Other (Specify) Fatanbreat 08/06/2007 Timonium, Maryland Dulaney Valley Memorial 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 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Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4 □ Pregnant at time of death 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 3 ☐ Probably 4 ☐ Unknown 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. 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DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mont 2:18 28 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number 217-20-1493 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 80 Yrs. Director January 6, 1927 Baltimore, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Howard 1 ☐ Yes 2 No Completed by Funeral Director Ellicott City 10e. Street and Number 3004 North Ridge Rd. 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) Collega (1-4or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Fenyes Germaine Meche P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: if Item 27 is any injury or other trauonce. Mr. Eugene L. Bandy 1505 Stone Ridge Way Bel Air, MD 21015 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □Cremation 3 □Removal from State Maryland Veterans Cemetery 08/02/07 4 Donation 5 Dother (Specify) Garrison Forest, Maryland 21. Signature of Funeral Salv 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NOCUN /Medical Due to (or as a confequence of) Examiner Mercu Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 ☐ Yes Certification: To Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours af To the Funeral D completely filled i the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Yeer)

State Registrar

AUG 8

07-05965

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kwan Lamar Cava		ugh Sta	te of Mary	land / Depar	tment of	Health an	d Mental	Hygie		ť	.011	
	R	egistrar . Decedent's Name (First, Middle	Last)	Cert	iiicale oi	Death			Reg. I			3. Time of Death
Physician Medical Examine		Kwan Lamar	Cava	naugh				A	nonth Da ugust 4, 20	07		0610 hrs
1.	4	a. Facility Name (if not institution		number)	1	4b. City, Town, or Cheverly	Location of De	eath		4c. County Prince (		s
	4	Prince George's Hospit	al Center B. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Yes	ar If Under 24	1Hrs. 8.	Date of Birth(	MM/DD/YYY	Y) 9. Birth	place (State or
Funeral Director	ľ	577-02-0710 1	1 <sup>X</sup> M 2 F		28 <sub>Yrs</sub>	Months Day		Min.	)3–16÷	1979	, o. o.g.	ntry)
	-	Jsual Residence of Decedent	I IVI Z I									10d. Inside City Limits
v any		10a. State 10b. County		10c. City,	Town or Locat	<sup>ion</sup> nington						1 Yes 2 No
land f shov	اق					10f. Zip Code			10g.	Citizen of W	/hat Coun	
e Mary	Director	1335 1st St.	NW				001			Ţ	JSA	
with th		11. Marital Status		Decedent Ever in U.	S. 13. Wa	as Decedent of H es, specify Cuba	ispanic Origina	( Specif	y Yes or No-		e - Americ	can Indian, Black,
death or item	Funeral	1 Never Married 2 Ma	1 Ye					3676 1 110	un, oto.,	Specify	Bl	ack
s after	ğ.	Widowed 4 Dive	or Dates:		16a Decede	Yes 2 <sup>X</sup> N nt's Usual Occup	ation (Give kin	d of work		6b. Kind of E		ndustry
2 hours	ed -	Elementary/Secondary (0-12)		en 1-4 or 5+)	during n	nost of working lif	e. DO NOT us	e retired)		Dri	Lvat	
036 thin 77 ne. r than	Completed	, , , , ,			becui							2
5-0 iled wi Hygie d other		17. Father's Name (First, Middle,	<sub>Last)</sub> Unkn	own			18.Mother's I		rst, Middle, Ma	anauc		
2121 ild be f Mental warke	o Be	19a. Informant's Name/Relations			19b. Mailir	ng Address (Str	eet and Numbe	er or Rura	al Route Number	er, City or To	own, State	Zip Code)
AD 2 shou h and 1 27 is r		19a Informant's Name/Relations Marvette Plu	nkett/			1st St						0 1 Town, State
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 7 spartment of Health and Mental Hygiene. prortant: If item 27 is marked other than jury or other traumatic event, the <u>Medica</u>	ı	20a. Method of Disposition  1	3 Remov	20b.	Place of Dispo crematory or c	sition (Name of other place)	emetery,				*	
Pages Pages ant: I		4 Donation 5 Other Sp	ecify:			Name and Addre						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	)	10	)8 W. N	orth A	Ave.	Balt	imore	e, Mi	D 21201
Physician	-	23a. Part I. Enter the disease, or	complications th	at caused the death	. Do not enter	the mode of dyin	g, such as dare	diac or re	espiratory arres	t, shock, or l	heart	Approximate Interval Between Onset and
Wedical	. 7	failure. List only one cause Immediate Cause (Final disease		Injuries								Death
<b>∢</b> caminer		or condition resulting in death)	Due to (or	as a consequence o	of):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence o	of):				(w)			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or	as a consequence of	of):						_	
recuted 1 and - transit		events resulting in death) Last	d									
e exectician arrial - t	dical	UNPENDED	AMEND	ED						Ond Date	of doliver	<u> </u>
Box 68760, e death certificate b the attending physical for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in t		res, outcome of pregive birth		etal death	3 Ectopic	oregnand	зу	Month	e of deliver	Day Year
× 68 h certi	iciai	past 12 months?	4 P	regnant at time of d	eath 5	Other (Specify)						
. <b>Bo</b> he deal y the al	Phys	Part II. Other significant condi	9	nknown	resulting in the	e underlying caus	e given in Par	11.	23e. Did tot	acco use co	ontribute to	the cause of death?
P.O. irres that the signed by t	þ	Part II. Other significant const.							1 Yes	2 🗸 No	3 Pro	bably 4 Unknown
rds, require been sig	Completed								24a. Was a autops		prior to	utopsy findings available completion of cause of
COF e law i le has t	ldu	1							perform 1 <b>V</b> Yes 2		death?	
n of Vital Recoling Physician: The law After this certificate has funeral director, page 2.8	a	25. Was case referred to medical					ace of Death (					
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2		ent 3 DOA	Other <sub>4</sub>		Home 5 18d. Describe h	Residence		er:
Division of Vital Records, tat or Attending Physician: The law requirers after death. After this certificate has been sided in by the funeral director, page 2 should the		27. Manner of Death  1 Natural 5 Per	ding Aug	Date of Injury Month, Day Year)   4, 2007	28b. Time of 0000 hrs		Yes 2		occupant au	ito collisio	on	
Sion	icati	2 Accident Inve	estigation 28e	Place of Injury - At	home, farm, st	treet, factory, office	ce building, etc		T C	inta\		Rural Route Number, City
Divi	Certification:	4 Homicide dete		ecify) Emergen				-	3rd & E, Cap	itol Street		
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Tuneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		(Direction of the	Physician: To th	e best of my knowle	edge, death oc	curred at the time	e, date and place	ce, and d curred at	lue to the cause the time, date a	e(s) and mar and place, a	nner as stand nd due to	ited. the cause(s)
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Medical	one) 2 Medical Ex  29b. Signature and title of certif	and mak	ner stated.	G.1G/G/ 111VO3U		ense number					Ionth, Day, Year)
	2	250. Signature and title or certif	WYT			0	C.M.E.			August	5, 2007	
or		30. Name and address of person	n who completed	cause of death (Ite	em 23a)							
4		David Fowler M.D.	Chief Medic	al Examiner	111 Penn	Street, Balti	more, MD 2	1201				
		31 Date filed (Month Day, Year	1 3	2 Registrar's Signa	ature	100						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar			Certificate of	Death	R	eg. No.	25347	
, s	Physicia		<ol> <li>Decedent's Name (First, Middle, Rowena</li> </ol>	Elaine	Ca	arter		2. Date of Dea Month	Day Year	3. Time of Death  O4:50 PM	
0	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		RAUI	Location of Death		4c. County of Dea	ith	
	Funeral Director		218-44-3144	6. Sex 1 □ M 2 ☐ 7. Age (In ) 60	yrs. last birth Yı	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Mov • ID	, Year) 1946 Mar	rthplace (State or Foreign ountry) y Land	
	Maryland f show ed at	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         N/A		City, Town					10d. Inside City Limits 1 √Yes 2 □ No	
	death with the Maryland ems 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 644 Brisbane	Road		10f. Zip Code			10g. Citizen of What C		
980	urs after deat al", or items 2 Examiner mu	by Funeral	11. Marital Status  1 ĂNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces?	in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 1 No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:		
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5+)		Decedent's Usual Occup Give kind of work done life. DO NOT use retire ata Entry C	during most of workir d)	ng	16b. Kind of Business  City of B		
and 2	the filed vertical Hygie ed other:	Be	12 17. Father's Name ( <i>First, Middle, L</i> James	ast) Yance		ata_entry o	18. Mother's Name	(First, Middle,			
Maryl	12 should h and Me 7 is mark raumatic	၉	19a. Informant's Name/Relationsh Wanda D. Betts	ip (Type. Print)	19b.	Mailing Address (Street	and Number or Rura		er, City or Town, State,		
nore, l	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp.	3 □Removal from State I		Disposition (Name of crematory or other pla Park Cemet		ate	20c. Location - City of Baltimore,	•	
Baltir			21. Signature of Funeral Service L						rk Funeral re, MD 212		
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused the only one cause on each line.  aa	IVE	ENDOCAR		r respiratory ar	rrest,	Approximate Interval Between Onset and Death 20 DAYS	
68760,8	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if y sent I imm Jate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a cord) c Due to (or as a cord) d							
. Box	ath certif aftending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pr 1 □Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3□Ectopic pregnand 5□ Other (specify)	у		23d. Date of d Month	lelivery Day Year	
ROWENA Records, P.C	uires that the de signed by the a ld be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No							to the cause of death?  Probably 4 Lander	
	The law require ate has been si bage 2 should b	Completed by	RENAL FASLURE, NYPERTENSION  24a. Was an autopsy performed?  1 Yes 2 140.						psy prior to prmed? death	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
-K.	ysician: The s certificate hadirector, page	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient	2 ER/Out	patient 3 DOA	26. Place of Deat her: 4□ Nursing Ho		one) dence 6 □Other (Si	pecify)	
CARTER, Division or Vital	Attending Physician: r death. ector: After this certifics by the funeral director, I	Certification: T	27. Manner of Death  1 1 1 2 Natural 5 Pending investigation 3 Suicide 6 Color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed and a color mixed							Rural Route Number,	
	그 원 등 드	Certif	4 Homicide determ	building, etc. (S	Specify)			City or To	wn, State)		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the basis of exa and manner stated	amination and	d/or investigation, in my	opinion, death occur	red at the time	date and place, and c	lue to the cause(s)	
	Viti To Cor	<		) · D.		4	21227		July 31		
	0		30. Name and address of person St AGNES (HOSPE)	who completed cause of death	(Item 23a) (	Type, Print) E, BAUTEN	ORE, NOD	212	2-9		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	BAUTEN					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Jeanette Cessna August 2007 3:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Health & Rehab Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 200-28-2652 1 M 2 F PÁ Director 09/12/1936 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State show ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21060 120 Sloane Drive Apt. H Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 9 3 ☐ Widowed 4 ☑ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) it of Health and Mental Hygiene. If Item 27 Is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Sales/Childcare</u> Retail/Childcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Faustina Bematri Antonio Fusco ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hankins 8044 High Oak Rd., Glen Burnie, i1D 21060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Department of Important: If any Injury or once, Metro Crematory 8/4/2007 |Baltimore, MD 4 □ Donation 5 □ Other (Specify 22. Name and Address of Facility 21. Signature of Funeral Service Lic Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Endomitrial Corcinons Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760,7 Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 12 No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an cate has to page 2 s autopsy performe certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 10 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day, Year)

DR. OCHANEY

29b. Signature and title of certifier

. Registrar's Signature book

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gran BURNE, MD

29d. Date signed (Month, Day, Year)

August 3,2007

DRIVE SUITE 208

29c. License number

D-40521

325 HOSPITAL

DHMH 17 Rev 1/2001

Registrar

	1 - For State Registrar	State of Marylan		artment of tificate of			jiene log. Nó.	1	25043
Physician	1. Decedent's Name (First, Middle, Last)  Josephine	Chittum				2. Date of Dea	Day 200	Year	3. Time of Death
/Medical Examiner	A FOR NO. OF THE REST			4b. City. Town.	or Location of Deat	August	4c. County of		8:45 P M
LXammer	Crofton Convalesce		nter	Crofton			Anne Arundel		
Funeral Director	5. Social Security Number 224-09-0343 6. Sex	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day AUG. 31	1912	9. Birthpla Count	ace (State or Foreign try) VA
and	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10	d. Inside City Limits
Mary February	Maryland Anne Ar				nton				1 ☐ Yes 2 ☑ No
or 28s	10e. Street and Number			10f. Zip Code	10011		10g. Citizen of W	hat Count	ry?
23a	538 01d Waugh Ch	· · · · · · · · · · · · · · · · · · ·			21113			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or items 23a or 28a-f show pintry or other traumatic event, the Medical Examinar must be motified at ance.  To Re Commisted by Funeral Director		2. Was Decedent Ever in U. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	t	Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S pan, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		- America , White, e	
72 ho	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occu	pation during most of wo	rking	16b. Kind of Bus	iness/Indi	ustry
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	30. Name and address of person who cor	npleted cause of death (Item	23а) (Туре, І	Print)					•
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State Registrar	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ore Cook	No.					

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

0

RON KHATKAR, MD., UNION MEMORIAL HOSPITAL,

32. Registrar's Signature

ROLLEN

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #30, perDVR,g870, 8/8/07 TT Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 4 2007 04:15aM JOHN WALTER DORSEY SR. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE ELLEN CHOICE WAY PARKTON If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months 1**⊠**M 2□ 05/15/1932 MARYLAND 218-28-4826 75 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No BALTIMORE PARKTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 ELLEN CHOICE WAY 21120 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN ELECTRICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARJORIE MINNICK JOHN C. DORSEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MOFFETT daughter 7 ELLENS CHOICE WAY, PARKTON, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State AUG 7, 2007 PIKESVILLE, MD DRUID RIDGE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. 21. Signature of Funeral Service Licenses

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-trar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Completed by within 24 hours after

To the Funeral Dire

completely filled in by

shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	as cardiac o	rrespiratory arrest,	Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b			
that initiated events resulting in death) Last	CDue to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)	23d. Date of Month	delivery Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death? Probably 4 □Unknown
			performed? deat	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
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examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Hor	me 5 K Residence 6 □Other (	Specify)
27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigatio		Work?	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number of City or Town, State)	or Rural Route Number,
29a. Certifier Certifying P	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, pation, in my opinion, death occurr	and due to the cause(s) and manne ed at the time, date and place, and	er as stated. I due to the cause(s)
29b. Signature and title of certifier	11	29c. License number	29d. Date signed (N	Nonth, Day, Year)
> rul 1	ellaw	D30529	8/6/	2007

Registrar

Paul Celano, MD Parkton, MD 31. Date filed (Month, Day, Year) State

32. **G**gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parte

10

07-05888 Mark Englehardt

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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3	DIVISION Of VITAL RECORDS, P.O. BOX 68/60,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Ce		ysician: To the best of niner:On the basis of e	examination and/or							
9	To To	Mec	29b. Signature and title of certifier	and manner state	ed.	29	9c. License	e number		29d. Date signe	ed (Mont	th, Day, Year)
			Theodor I	1. Kirx J	hy mi		O.C.N	M.E. OCM	E	August 2, 2	007	
	9		<ol> <li>Name and address of person v Theodore M. King, Jr.,</li> </ol>		of death (Item 23a) Medical Exam	niner 111 P	enn Str	eet, Baltimore	e, MD 21201			
	S	ate	31. Date filed (Month, Day, Year)	2607 32 Regis	strar's Signature	poli						
	Regist	(GII	Alliauo	1001		<u> </u>						

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 1:15 AM Emery Jeannette Anne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Nursing Home Towson Baltimore 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs. 218-58-9642 92 Pennsylvania Director Usual Residence of Deceden with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 77 is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Towson Maryland Baltimore Director 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 7001 Charles Street 21204 U.S.A Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 Ie marked other than "naturel", or Iteme 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 Home Maker Own Home NA17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spencer Anna McDonough 2 Ravmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Spencer ( Daughter ) 903 Falls Road Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 9. permit. Pages 1 Department of H Importent: If Ite any injury or ot once. tx Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Bast Point, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service License ash mach + 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Intl. Inter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heer failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition emontia **Physician** resulting in death) /Medical Due to (or as a consequence of) Heart Failune Examiner Constitue

Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 WUnknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 25 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and clane and direct the time, date and place, and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Cartifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OE. Timonium rd. #209 Timonium, MD 21093 cyrus 31. Date filed (Month, Day, Year) egistrar's Signature **AUG 08** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 01, MINNIE REA FLOWERS 2007 10:06A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M **XX**F Months Davs Hours 370 38 5963 78 OCT. 05, Director 1928 LOUISIANA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d Inside City Limits a or 28a-f show t be notified at 1√XYes 2 □ No Director MD PRINCE GEORGES CLINTON permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or non-1 any injury or other traumatic event, the Maniferial. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7910 PINEWOOD DRIVE 20735 UNITED STATES Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes Y No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📈 o Specify. Specify: BLACK ₩Widowed 4 Divorced 9 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSE AIDE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RODELL MONTGOMERY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENDOLYN WASHINGTON / DAUGHTER 7910 PINEWOOD DRIVE CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 8/08/2007 ALEXANDRIA, VA 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cause (Final Cau Approximate Interval Between Onset and Death ARDIOGENIC HOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown s been signed by t should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a Was an has autops page certificate 25. Was case referr o medical examiner? rector. Be 26. Place of Death (Check only one) 21XN0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 2 ER/Outpatient 3 DOA Inpatient ÷ this Date of Injury funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Year) (Month, Day Injury within 24 hours after community to the Funeral Director: Aft 1 Tyes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

requires that the death certificate be executed P.O. or Vital Records, Physician: or Attending Division the Hospital

State Registrar 31. Date filed (Month. Day. Year. AUG 0 8 2007

d title of certifie

linh

29b. Signature at

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date gned Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 30 05,200 /Medical 4b. City, Town, or Location of Death Examiner If Under 1 Year 6. Sex 8. Date of Birth (Mopth, Day, **Funeral** Year) Min 1 M 2 T 220-12-9229 Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 U5A permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Fxaminar must by Funeral 14. Race · American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Educational 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Daan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNSON Geneva 20b. Place of Disposition (Name of 20a. Method of Disposition crematory or other place. 1 Burial 2 □ Cremation 3 ☐Removal from State 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Chatman-5240 Reisterstown 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DISEASS MYPERTENSINE CARDIOVASULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exam burial-trar Due to (or as a consequence of) physician Medical Certification: To Be Completed by Physician/Medical the ass attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy for Month Day Year signed by the at the detached for 4⊡Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2010 1 | Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

UMA

BULLNESS 31. Date filed (Month, Day, Year) Registrar's Signature 2007 AUG 08

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVS

29c. License number

D 5059107

REISTERSTOWN

29d. Date signed (Month, Day, Year)

21136

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** NICKOLAS JOSEPH FERRERA AUG. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2788 FERRERA DR TANEYTOWN CARROLL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2□ F 69 Director 215-34-9945 8/16/1937 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County r 28a-f she notified a Director CARROLL TANEYTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 21787 USA "natural", or items 23a dical Examiner must b 2788 FERRERA DR. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: WHITE 3 ☐ Widowed 4 X Divorced Completed r than "natur. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER CONSTRUCTION 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOMAGRO **FERRERA** FRANCES JOSEPH ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship. (Type, Print) co 2797 FERRERA DR., TANEYTOWN, MD JOSEPH N. FERRERA - SON if of Heal 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. MARY'S CEM. ST. 8/9/07 SILVER RUN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 dan m 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden De /Medical Due to (or as a consequence of) Examiner Driman Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of

Examiner

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director,

uneral

within 24 hours a

physician ar s the burial-t Physician/Medical <u>}</u> Completed To Be Certification:

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 PUnknown

23d. Date of delivery

Month

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

3. Time of Death

4:30 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

MARYLAND

Black, White, etc.

autopsy performe 1□ Yes 2 ☑ No 26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

mb 21157 LATHA NAGANNA, MD.

State

Medical

31. Date filed (Month, Day, Year)

Poole

29b. Signature and fitle of certifier

AUG 08 2007

5 Pending

investigation

6 Could not be determined

32 Registrar's Signature

Jestm:nster

2 ER/Outpatient 3 DOA

28h. Time of

DHMH 17 Rev 1/2001

Registrar

			For	State of Marylan	-				property and the	
			State Registrar		Cei	tificate of I	Jeath		No.	2 Three of Davids
	Physicia	-	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	MARIAN GURL			41. Oit. Town	Leasting of Dooth	August 6	2007 4c. County of Dea	11:41 a <sup>M</sup>
,	Examin	er	4a. Facility Name (If not institution, give st			.,	Location of Death	'		
			221 PERRYWOOD CT.  5. Social Security Number 6. Sex	APT 101 7. Age (In yrs.	last birthday)	ABEF If Under 1 Year	DEEN If Under 24 Hrs.	8. Date of Birth	HARFORD 9. Bir	thplace (State or Foreign
	Funeral Director		1 🗆	M 2⊠F 69	Vre	Months Days	Hours Min.	(Month, Day, Y DEC. 20	ear) Co	ountry) W JERSEY
а	-400		137-28-8608 Usual Residence of Decedent					TDEC. 20	1937   101	W OUKDUI
	ylanc now at		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	a-f st ified	tor	MARYLAND HARFORD	CO	ABERD	EEN				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	th wi		221 PERRYWOOD CT.	APT 101			.001		U.S.A.	
	r dea	Funeral	11. Iviantai Status	<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
36	within 72 hours after death with the Maryland tene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes <b>2\</b> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Specify:		Specify: BL	ACK
ë	hour: tural'		15. Decedent's Educa		16a, Dece	dent's Usual Occup	ation	16	b. Kind of Business	:/Industry
<u> </u>	n 72 ''nai	Completed	(Specify only highest grade	completed)	i (Give	kind of work done DO NOT use retired	during most of wor			,
21215-0036	withi iene. thar the M	m o	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	MAC	HINE OPER	RATOR		OLINE PLA	STICS
ō	filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Ma	iden Surname)	
Maryland	lenta lenta rked ric ev	To B	ASTOR GURLEY S	SR.			MARY A	NN MILLER		
ary	shot and N s ma		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Number, (	City or Town, State,	Zip Code)
Σ	and 2 saith n 27 i		Nadiyah Pollins/Gr				Rd., Ap	t B3, Bal		
ore	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2   ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date 20	c. Location - City or	r Town, State
Ĕ	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specify)			EMATORY	08-1	1-07 В	ALTIMORE,	MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Sphyice License	0 1 1 1	W	2. Name and Addre $  ext{ILLIAM}   ext{C}$	BROWN CC	MM FUNERA	L HOME-HA	RFORD, P.A.
_	20 = e g			allew				BLVD., A		
Ш			23a. Part1. Boto the disease, or complic shock, or heart failure. List only on	eations that caused the dea e cause on each line.	th. Do not en					Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Hyperes	ne	Cardie	Vascel	lar dis	ease	
	/Medical Examiner		Toolahing in doday	Due to fr as a conse	quence of):					
		-	Squentially list conditions b.	Due to (or as a conse	quence oi):					
. 0	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Õ.	execu n and ial-tra	Exal	resulting in death) Last	Due to (or as a conse	quence of):					
8760,0	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dical	d							
9	tificat ig phy as th	edi						-		
Box	leath certific attending p	an/N	23b. was decedent pregnant	Bc. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fe	nancy tal death 3	⊒Ectopic pregnanc	У		23d. Date of de Month	elivery Day Year
	ne deat the att	sicis	in the past 12 months? 1 ☐ Yes 2 💢 No	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Fear
P.0	that the d ed by the detached	Physician/Me	9 ☐ Unknowfi				en in Deet I	220 Did tobs	ucco uso contributo	to the cause of death?
	res tha signed I be det	b	Part II. Other significant conditions con	11	esulting in the t	indenying cause gr	ven in ranti.	1 ☐ Yes		Probably 4 Unknown
ord	w requir been si should	ted	_ grove ru	ng wor	reco					
ec	aw as b 2 s	Completed		<u>//</u>				24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Ξ		Son						perform 1□ Yes 2	No 1 ☐Ye	
/ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Lou	ner.	ath Check onl one		
or Vital Records,	hys this	ျ	res 2 100	1 ☐ Inpatient 2 [	ER/Outpatie	nt 3 DOA	4   Nursing I	Home 5 Resider 28d. Describe hov		pecify)
	ing Affe une	<u>io</u>	27. Manner of Death  1 X Natural 5 ☐ Pending  2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No	Zod. Dodonios nov	r injury boodined	
isio	Attending r death. ector: After by the funer	icat	3 Suicide 6 Could not be	28e. Place of injury - At	nome, farm, s			28f. Location (Stre	eet and Number or I	Rural Route Number,
Division	늘 약 늘 ㄷ	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)			City or Town,	State)	
	Hospital 24 hours a Funeral I		29a. Certifier 1, Certifying Phys	ician: To the best of my ki	nowledge, dea	th occurred at the t	ime, date and plac	ce, and due to the ca	use(s) and manner	as stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only one) 2 Medical Examin	ner: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my	opinion, death occ	curred at the time, da	te and place, and d	ue to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	1/1/	2	29c. Licen	se number	29	d. Date signed (Mo	nth, Day, Year)
	, ,, ,		Burand !	(1800 MI)	MME	100	14206	$^{\circ}$	ugust !	7,2007
	2		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type	, Print)	1011.11	1-0/	1	
	3		BERNARD T. YO	IKNA MD, D	ME	1614 CHG	RUYVIL	LE ROAD	BEL AIR	,Md 21015
	St	ate	31. Date filed (Month, Day, Year)	62. Registrar's Sig	nature	esco			,	

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** aususT 3:05 AM Alice study 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1□M 2**√**F Yrs. 218-22-376 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 Pres 2 No Baltimore MI Funeral Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r 21223 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married African 1 Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☑ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD parent 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Payson MD ZIZZ3 of Health a Edwing Daughter Baltimore Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State edan Hill Cen 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Funeral Service, P.A. 21. Signature of Funeral Service License Baffimore MD 21208 Belan 5126 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final accubines Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part K Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 StInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Matural 5 Pending investigation within 24 hours after town. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Osurno

AUG 08

2007

icardo

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore

Maryland

2000 West Baltimore Street

rar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

naid Jacob F		1- For State Certificate o		Reg. No.			
Physic	ian/	1. Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day	3. Time of Death Year 1033 hrs		
al Exam	iner	RONALD JACOB HOUCK  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 4, 2007	County of Death		
		University of Maryland Medical Center	Baltimore City				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		DD/YYYY) 9. Birthplace (State or Foreign		
Director	1	218.21.0382 XX M 2 F 19 Yr	SEP 9, 1987	Country			
w any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local		10d. Inside City Limits  1 X X Yes 2 No			
Maryland 28a-f show d at once.	to	MD BALTIMORE	10f. Zip Code	10g. Citiz	zen of What Country?		
after death with the Maryland "a", or items 23a or 28a-f shov iner must be notified at once.	Director	10e. Street and Number	21226		USA		
ith the 23a o notifi	al D	8111 HOLLY RD.  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? ( S		14. Race - American Indian, Black,		
aath w items ust be	Funeral	1 X X Never Married 2 Married Armed Forces?	Yes, specify Cuban, Mexican, Puerte		White, etc.		
fter de F., or		0 111001100	Yes 2 XX No specify:		Specify: WHITE		
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decede during	ent's Usual Occupation (Give kind of most of working life. DO NOT use re		Kind of Business/Industry CHEN EQUIPMENT		
6 n 72 h an "n ical E	Set	Elementary/Secondary (0-12) College (1-4 or 5+)			CIALIST, INC.		
5-0036 led within 72 Hygiene. other than	Completed	12 1NS 17. Father's Name (First, Middle, Last)	TALLER 18. Mother's Nam	ne (First, Middle, Maiden	Surname)		
21215-0036 Muldibe filed within 7 Mental Hygiene marked other than		RONALD F. HOUCK		N MILLIGAN			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 shouldbe filed within 72 hours Department of Health and Mental Hygiene. Important: If lieu 27, 15 manked other than "matur improve on other transmarie event, the Medical Exam	0	19a. Informant's Name/Relationship (Type, Print )	ing Address (Street and Number or		ity or Town, State, Zip Code)		
imore, MD 2 Pages 1 and 2 shou ment of Health and N tents: If item 27 is no		1.01.1.25	HOLLY RD., BALTIMORE		Location - City or Town, State		
s I an of Hea		20a. Method of Disposition  20b. Place of Disposition  1 XXBurial 2 Cremation 3 Removal from State crematory or	osition (Name of cemetery, other place)	Date 200.1	Eddardi Sity of Torring Clare		
Page Page ment c		4 Donation 5 Other Specify: MEADOWRIDG	E MEMORIAL PARK AUG	. 8, 2007 ELK	KRIDGE, MD		
Baltimore, permit. Pages I at Department of He Important: If ite		A COL	Name and Address of Facility INK FUNERAL HOME, PA				
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Medica		failure. List only one cause on each line.			Death		
Examine	r	Immediate Cause (Final disease or condition resulting in death)  a. MUTUPLE ITITUTES WITH COMPLICATION  Due to (or as a consequence of):					
		Sequentially list conditions, b.					
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.	3 1003				
والم	Examine	events resulting in death) Last Due to (or as a consequence of):					
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60, sate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			3d. Date of delivery		
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SiOl Atten	by the	2 Accident Investigation 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.	28f. Location (Street	and Number or Rural Route Number, City		
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	2	29b. Signature and title of certifier	O.C.M.E.				
		30. Name and address of person who completed cause of death (Item 23a)					
H		Ling Li, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, MD 21201				
Boo	Stat	R117 11 V /1311/ 1/7/2-2	rade				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ,20 HARRISON AUGUST 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Woods Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 9, 19 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F Yrs. Director 416-46-8567 1919 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 7 is marked other than "netural", or items 23a or 28a-f shor treumatic event, the Medical Examinations to items 1 Yes 2 XNo Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2019 Kelbourne Rd. Apt. 102 21237 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "netural", or Iten eny injury or other treumatic event, the Medical Example 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mezzile Allen Leonard Harry Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) H. Howard Harrison/Son 2231 Holland St., West Columbia, SC 29169 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 [3] Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 8-8-07 Charlotte, N. Carolina 21. Signature Funer Fervice Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enler the disease, or complications that caused it shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ng physician a as the burial Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate No No 1 Yes RE No 1 Yes To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death Check on one examiner Other: Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pendina within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AMOMA HANGE, 821 N. EWOUNGE, 4: #308 3) Date filed (Month, 3. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene U State Registrar Amend #30, perDVR, g870, 8/8/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 2007 10:45a M ELIZABETH R. HILGENBERG /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE COCKEYSVILLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07/08/1906 BROADMEAD 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** NEW YORK 1 ☐ M 2 💢 F 220-46-2496 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Itams 23a or 28a-f show instrinust be notified at 1 ☐ Yes 2 No COCKEYSVILLE BALTIMORE Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21030 TISA 13801 YORK RD Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married other traumatic avent, the Medical Exami 1 ☐ Yes 2 No ö Specify: WHITE Specify Completed by 3 N Widowed 4 □ Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HOUSEWIFE HOMEMAKER other 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental Hy If Item 27 is marked other 17 Father's Name (First Middle, Last) Be ELIZABETH L. ROWE THOMAS M. RIANHARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an P.O. BOX 338 STEVENSON, MD. 21153. JOHN C. HILGENBERG(SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ξ permit. Page Department of Important: If eny injury or once. DRUID RIDGE 08/16/2007 PIKESVILLE, MD. 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO. 21. Signature of Funeral Service Licensee YORK RD MONKTON, MD. 16924 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for all a nonsequence off Examiner and Due to (or as a consequence of): the attending physician Physician/Medical as the Box IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 PNo be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 1 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 Yes of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Yeer) in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Division 5 Pending 1 ANatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signaturg and title of certifier 30. Name and address of person who completed cause of death (Item 23ar (Type, Print) Barbara Jean Carroll, MD Broadmead Cockeysville, MD 32 Registrar's Signature 31. Date filed (Month, Day Year) 8 2007 State Registrar

2121

Maryland

Baltimore,

o.

Beatice Harmon 8/6/07 12AM

		For State	<b>e Type or Pri</b> State of M	aryland / Depa		lealth and I	-	giene	ible.
Physici /Medi		1. Decedent's Name (First, Middle,	Last)	Cei	runcate of	Dealii	2. Date of De Month August	Peath Day 6, 200	3. Time of Death 7 12:00 A
Examin	ner		ng Home	ge (In yrs. last birthday)	4b. City, Town, o  Parkvi  If Under 1 Year  Months Days		8. Date of Bi	rth ay, Yea <i>r)</i>	9. Birthplace (State or Foreign Country)
Director pow tell		212-07-7040           Usual Residence of Decedent           10a. State         10b. County		95 10c. City, Town or Lo	ocation		6/12/	/12	Maryland  10d. Inside City Limit
with the Ma a or 28a-f s be notified	Director	Md Baltin		Pa	arkville 10f. Zip Code			10g. Citizen of	1 □Yes 2 N What Country?
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.  em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at	by Funeral	8820 Walther B.  11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	No I	21 Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 No	234 Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	US 0- 14. Rac Blac Specif	ce - American Indian, ck, White, etc.
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uld be fill Mental H irked oth	To Be	17. Father's Name (First, Middle, L  Rocco DeCarlant	•				ne (First, Middle V. DeAr	e, Maiden Surnar ngelis	me)
and 2 sho ealth and 1 m 27 is ma ner trauma	i	19a. Informant's Name/Relationshi		961 A	ng Address <i>(Street</i> Arundel D		nold, Ma	ryland_	21012
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 Roremation 3  4 Donation 5 Other (Sp.  21. Signature of Funeral Service Li	ecify)	@ Loudon	Park  2. Name and Addre	8/7 ess of Facility Lo	udon Pa	Baltimo: rk Funer	
Physician /Medical Examiner	<i>y</i> . I	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a						y 1 and 21229  Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lusease or injury that initiated events resulting in death) Last	С	a consequence of): a consequence of):					
The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnance	у			ate of delivery onth Day Year
w requires that been signed t should be det	þ	Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.		tobacco use cont Yes 2 ☐ No	tribute to the cause of death?  3 Probably 4 Unknow
	Completed						24a. Was auto perfo 1□ Yes	psy ormed2	Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ding Phys After this funeral di	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 V6  27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 3 Sulcide 6 Could no determin	26. Place of Dealer: 4 Nursing H	ome 5 ☐ Resi 28d. Describe	idence 6 Oth				
Hospital 4 hours a Funeral I	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis of and manner st	of examination and/or in	h occurred at the tinvestigation, in my o	me, date and place	e, and due to the	cause(s) and mand the cause (s) and place,	anner as stated. and due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifie		>	29c. Licens		,		d (Month, Day, Year)
			- AV 880	leath (Item 23a) (Type, Watthe	Print) PRIVA	Parville	e MD	4234	
Sta Registr		31. Date filed (Month, Day, Year)	8 2007 <sup>22. Registr</sup>	ar's Signature	Gares			•	

**Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, To the Hospital or within 24 hours aft To the Funeral Di completely filled in

with the Maryland

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of a 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions  AL2HEIMEA			g cause given in Part I.		se contribute to the cause of death? ☑No 3☐ Probably 4☐Unknown
				24a. Was an autopsy performed? 1□ Yes 2√2√No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 No	Hospital: 1: Inpatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 Suicide 6 Could not 4 Homicide determine		ome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
	Physician: To the best of my kn caminer: On the basis of examin and manner stated.				

29c. License number

RESOOO

29d. Date signed (Month, Day, Year) 08/04/2007

.7 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IHEAGWARA, 3001-S. HANOVER ST, BALTIMORE, MD 21225 OYIJE

31. Date filed (Month, Day, Year)

1 hea

29b. Signature and title of certifier

32. Registrar's Signature

quaza.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 300T 30 Joseph E. Kotowski 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Maryland Health Care System Point Herry If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/29/1927 Birthplace (State or Foreign Country) Social Security Number 1X M 2 ☐ F 79 Maryland 218-22-5439 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 505 Foster Knoll Drive 21085 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Self-Employed Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Lasek Joseph Kotowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ann Kotowski 21085 (wife) 505 Foster Knoll Drive - Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. 08/07/2007 | Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 assal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **UNKnown** disease or condition resulting in death) Due to (or as a consequence of) ostate **UURUOMU** Sequentially list conditions if any, loading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unknown iarcinoma Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural

Box 68760 Ö ۵ Records, or Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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"natural"

Is marked other than

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau once.

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-transit

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certificate be

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Baltimore, Maryland

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Physician/Medical

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Completed

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Certification:

or Attending Physician: this To the Funeral Director: After the completely filled in by the funeral Division death. To the Hospital within 24 hours a To the Funeral E Hospital

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., YA Moryland

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

AUG 0 8 2007

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Health Care System, Perry Hint, MD. 21902

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 45 AM 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Mary Medical System land Niversitu N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Se 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 212-42-2907 1 ☐ M 2 🔀 F Hours 63 Director Maryland 25, 1944 Jan, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla nathment of Health and Mental Hygiene. ortant: If item 278 and and the dother than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 4020 A Annapolis Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lawrence Fragle Anna Buzewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4020 A Annapolis Rd., Baltimore, MD 21227 John Keil (Husband) 20b. Place of Disposition (Name of complete, crematory or other place)
Baltimore Crematory
Loudon Park 20a. Method of Disposition 20c, Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 8/4/07 Baltimore, Marvland 4 Donation 5 Dother (Specify) Loudon Park Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -ongestive Hear OURR /Medical Due to for as a consequence of) Examiner oronary 148ar Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the phys IF FEMALE: if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: To 1 Inpatient 2 □ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide the Hospital 11 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD

State Registrar

DHMH 17 Rev 1/2001

frar's Signature

Himore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary Florence Flower Kwiatkowski August /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) County of Deat Examiner Anne Hruno Baltimore Washington Medical ( 8. Date of Birth (Month, Day, Year) Sept. 25, **Funeral** 1 ☐ M 2 🔀 F 87 217 05 2530 Sept. 1919 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show must be notified at Glen Burnie Director Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or U.S.A. 21060 8 Glenwood Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🗓 No <u></u> 3 X Widowed 4 ☐ Divorced AW TOTANONI, May Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ward Myrle Waxter e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Glenwood Drive Glen Burnie, Maryland 21060 Sharon Currie / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 8/7/2007 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signal e Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYO CARDAAL /Medical Due to (or as a consequence of) **Examiner** STAGE Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner pue burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

7.45

Birthplace (State or Foreign Country)

Day

Ren Burnie M

Year

10d. Inside City Limits

1 ☐ Yes 2X No

2007

IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be 1 ☐ Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifie

MI

cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

Hospital or Attending Physician: The law requires that the death certificate be executed signed by this After t after death Director: filled in by within 24 hours a To the Funeral C

> 10 State

se and address of person who o

AUG 0 8 2007

31. Date filed (Month, Day

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVI		Certificate of	Death		g. No.	23:57
	Physicia	ın	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month August	Day Voar	3. Time of Death 7:20 AM
	/Medic	- 43	Pauline C. Lefteris  4a. Facility Name (If not institution, give street and number)	Esambli	4b. City. Town, or	r Location of Death	August	4c. County of Dear	
	Examin	er						Baltimore	9
	Funeral			Woods ge (In yrs. last birt	ROSSV1 thday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	hplace (State or Foreign
	Director		215-22-6899 1□M 2⋤F	87	Yrs. Months Days	Hours Min.	11/3/19		est Virginia
	pu. »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	anyla shov	7		Too. Oity, Town					1 ☐ Yes 2X No
	the M	ect	MD Baltimore  10e. Street and Number		10f. Zip Code	Rossville	10	g. Citizen of What Co	vunto/?
	with a or	ă	9200 Franklin Square Dri	ve		21237	10	United S	*
	ns 23 mus	Funeral Director	11 Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Ame	
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3	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specity:		Specify: W	nite
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7	iled v Hygie ther t nt, th		8 17. Father's Name (First, Middle, Last)	RE	etail	18. Mother's Nam	e (First, Middle, M		
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	should nd Me mark matic	은	Harry Cardiges  19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing Address (Street			City or Town. State.	Zip Code)
<u>2</u>	nd 2 %		Linda M. MacGregor (Daughte					e, Maryla	
<u>ה</u>	f Hea f Hea item othe		20a. Method of Disposition	20b. Place of	Disposition (Name of ry, crematory or other place	i		20c. Location - City or	
5	Page lent o nt: #		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	•	llawn Cemete		/2007	Baltimore	Marriland
סמור	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of uneral Service Licensee	7	22. Name and Addre	ss of Facility			
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	/Medical Examiner		resulting in death)	a consequence of					
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200	andin use	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	e pf pregnancy 2  Fetal death	3 ⊟Ectopic pregnancy	.,		23d. Date of de	livery
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5	Phys r this ral dii	2	1 ☐ Yes 2 No rospital: 1 ☐ Inpat 27. Manner of Death 28a. Date of Inj		tpatient 3 DOA Citi Fime of 28c. Injur	4 Nursing Ho	ome 5 Resider	nce 6 Other (Spe	ecify)
_	ding h. After fune	tion	Natural 5 Pending (Month, Da 2 Accident investigation		njury Wor	rk? Yes 2 ∐ No	200. 200020 1.01	wingsry occurred	
5		ca	3 Suicide 6 Could not be 28e. Place of in	jury - At home, fa	rm, street, factory, office		28f. Location (Str.	eet and Number or R	ural Route Number,
	dea dea octo		4 Homicide determined building, e	tc. (Specify)			City or Town,	, State)	
DIVISION OF	al or Atte after des I Directo d in by th	ertit		of my knowledge	e, death occurred at the til	me, date and place	and due to the ca	use(s) and manner a	s stated.
DIVISION	ospital or Atte hours after des ineral Directo iy filled in by th	sal Certification:	29a. Certifier 12 Certifying Physician: To the besi	of avamination or	wor investigation, in my (	opinion, death occu	reu at the time, da	are and place, and du	
DIVISION	the Hospital or Atte iin 24 hours after des the Funeral Directo ipletely filled in by th		(Check only one) 2 Medical Examiner: On the basis and manner s	of examination and					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to completely filled in by the funeral director, page 2.	Medical Certif	(Check only 2 Medical Examiner: On the basis	of examination and tated.	29c. Licens			d. Date signed (Mon	th, Day, Year)
DIVISION	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the		(Check only one)  2 Medical Examiner: On the basis and manner s  29b. Signature and title of certifier	of examination and tated.				7 7	th, Day, Year)
DIVISION	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by th		(Check only 2 Medical Examiner: On the basis and manner s  29b. Signature and title of certifier  30. Name and address of person who completed cause of	of examination and tated.  W >  death (Item 23a) (				7 7	th, Day, Year)
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		•	For State Registrar	State of Maryland		ent of Heate of E			iene () () og. No.	7	25460
			1. Decedent's Name (First, Middle, Las	. /		T 0		2. Date of Death Month		Year	3. Time of Death
	Physicia /Medic	_	JAMES	MATTHEU	15 0	IR.		august	parent, r	007	12:10 AM
br.	Examin		4a. Facility Name (If not institution, give	street and number)	4b. (	ity, Town, or	Location of Death	0	4c. County of	of Death	
			BON SECO	URS HOSPIT.	AL	BAL	TIMORI				
	Funeral Director		d15-30-7410	$\stackrel{\text{gx}}{\times}$ M 2 $\stackrel{\text{g}}{\square}$ F $\stackrel{\text{7. Age (In yrs. last}}{67}$	Yrs. If Un	ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	1939	9. Birthp Cour	place (State or Foreign
	and *	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location					1	0d. Inside City Limits
	daryli f sho	ō	mD	$\mathcal{P}_{\alpha}$	Himor	70					1 XYes 2 □ No
	the 28a	Director	10e. Street and Number	^		. Zip Code		10	0g. Citizen of W	hat Cour	ntry?
	3a or		2518 Harlem	Avenue		216	216		Uk	SA	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	ecedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ	can Indian, etc.
9	or ite	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 <b>X</b> No If Yes, Give		s 2 No	Specify:		Specify:	-1	COL
5-0036	72 hours after death with the Maryland natural, or Items 23e or 28e-1 ehow dical Examiner must be multified at	q p	3 Widowed 4 Divorced	Year or Dates:			ation .		16b, Kind of Bu	Cipaes/In	duetor
15	"nat	lete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's (Give kind o life. DO NO	osual Occupa if work done a OT use retired,	during most of work	ring		1 ]	dustry
2121	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	led: cal	Tech	miciar	$\gamma$ k	Johns	Ho	pKins
	illed i Hygie other	BeC	17. Father's Name (First_Middle, Last)				18. Mother's Nam	e (First, Middle, M	Aaiden Sumame	∍)	
<u> a</u>	Mental Mental arked c	ToB	James P. Ma	Hhews, Sr	,		Lun	ice la	urner		
Maryland	2 should and Men is marke sumatic	•	Pa. Informant's Name/Relationship (	ype, Print)	19b. Mailing Add	iress (Street a	and Number or Rui	ral Route Number	City or Town,	State, Zip	Code)
_	1 and Health sem 27 other tr		Carol Crecy	oister)	e of Disposition	Mount		Date Date	20c. Location -	pring	Was State
Ore	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition 4  1 Burial 2 X Cremation 3	Removal from State Cem	etery, crematory	or other place			D - 11.	City of To	a M
Baltimore,			* 4 □ Donation * 5 □ Other (Specify  21. Signature of Funeral Service Lisen	01. 0	en No	un L	8 Giren	0/2007	Dathi	$\gamma \sigma r$	e, MD
Bal	permit. Departr Importa any inju		21. Signature of Pullera Service Copil	Msoons	515	cagning	more Nat	106	Roll-mi	re n	D 21229
			23a. Part1. Enter(the disease, or comp	olications that ceused the death.	Do not enter the	mode of dying		or respiratory arre		/	Approximate Interval Between
	Physician		shock, or heart failure. List only immediate Cause (Final	one cause on each line.	MORIA	DV	EMP	alisa	n		Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequer		_/_	21111	021-1	/		
Е	Examiner		Conventially list conditions	, ACUTE	RE	NAL	- FAI	LURE			
Ä	₽ 4	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer							
	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequer	1 CER	MA					<u></u>
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687	phys phys s the			d					7		
Box (	death certifical attending phy of for use as th	υ/Μ€	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					23d. Date	e of deliv	ery
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de		oic pregnancy or (specify)			Mor	nth	Day Year
P.0	at the by th	Physiclan/Med	9 Unknown	9□ Unknown							
	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underly	ing cause give	en in Part I.			ibute to t 3 □ Prol	he cause of death?
ord	seen s	ted									
Records,	The law sate has b page 2 st	Completed						24a. Was a autops	n 24b. V	Vere auto rior to co leath?	opsy findings available impletion of cause of
al F	: The icate hi				<u></u>			1 ☐ Yes	20 No 1	Yes	2 □ No
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of	Physic this stal d	-	27. Manner of Death		8b. Time of	28c. Injun Work		28d. Describe ho			197
ion	Attanding ir death. ector: After by the fune	atioi	1 Aatural 5 ☐ Pending 2 ☐ Accident investigation		Injury M		Yes 2 □No				
Division	er des rector	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, fa	actory, office		28f. Location (St City or Town		er or Aur	al Route Number,
	ital or irs afte ral Dir led in	Cer									
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		ysician: To the best of my knowle niner: On the basis of examination and manner stated.							
	ro the vithin 2 ro the comple	Mec	29b. Signature and title of certifier	1 16 -		29c. Licensi			9d. Date signed	,	
	-310		1 Kopita	K. Cruf	M. J	10	0303	55 6	Engu.	15	1,2007
	10		30. Name and address of person who	completed cause of death (Item 2	(Type, Print)	F	0303. BON S	E 11 -:	100	41	
Į.	Ü		KOSITA I	K. CKMZ	M.D	) /5	DON 5	E COU	(145)	170	SPITAL
q	Sta Regist		31. Date filed (Month, Day, Year)	32 Reģistrar's Signatur	A	9.					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:30 AM 9 200 Annie Bell Mitchell tuoust /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HGNES HOSPITAL JAKTI MORE Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 XF 58 1, 1948 Georgia Director 106-40-4414 Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10h County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 XNo Item 27 is marked other than "natural", or Items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified. Directo Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 USA 839 Williamsburg Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Hudson West Rosa Bell Broome ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health wood, MD 21040 20c. Location - City or Town, State 839 Williamsburg Court, Edgewood, MD of Disposition (Name of Date 20c. Location - City <u> Eddie E. Mitchell Jr./Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Calverton National Cem. 8-10-07 Calverton, New York 22. Name and Address of Facility McComas Funeral Home, P.A., Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter their sease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he strailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 WEEKS (ENINGITIS Physician ARCINOMATOU /Medical Due to (or as a consequence of) Examiner HOWTHS TETASTATIO REAST if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Certifier completely (Check only one)

Records, Vital 回っつる Division

IANA 31. Date filed (Month, Day, AUG State 08 Registrar

30. Name and address of person who comp

Signature an

H. GRIFF

d cause of death (Item 23a) (Type, Print)

900

29c. License number

HIEDUE

29d. Date signed (Month, Day, Year)

DALTIMORE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year August 2, 2007 10:15 A M Raymond Ellsworth Marquardt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4515 Parkmont Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | April 30, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Months 1 → M 2 □ F 89 215-12-5432 1918 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Modical Examinant he notified at N/A MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4515 Parkmont Avenue 21206 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 🔼 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other ti
any injury or other traumatic event, tite
once. Aircraft Worker Aviation other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Erich Marguardt Anna Buettner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Marquardt- Wife 4515 Parkmont Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial 8/4/2007 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, Maryland 21206 Part Enter the disease, or tomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUDDEN DEATH /Medical Due to (or as a consequence of) Examiner AHLZEMERS/ DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed HYPERTENSION Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERLIPIDEMH 3 Probably 4 Unknown ATMAZ FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 200 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3[] DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation s after death.
I Director: Aft d in by the fur 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10036951 MD August 3, 2007 no completed cause of death (Item 23a) (Type, Print 30 Name and ac REGISTRAT'S Signature Med. Health Group. of Bel Air 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

	1	For State Registrar	State of Ma	aryland / Dep Ce	artment of rtificate of			Reg. No.	2507.
Physician /Medical	1 	1. Decedent's Name (First, Middle, Last,	MAST	Maste Sp		or Location of Death	2. Date of De Month	Day Year 4 200	7 5:10 HM
Examiner Funeral Director		La. Facility Name (If not institution, give  CARCOLL HOSE  6. Second Security Number  218-74-4252	CENT	ER e (In yrs. last birthday 48 Yrs.	Months Days	PU ST 37 (	8. Date of Bir (Month, Da	th 9. Bi	
a-f show			L	10c. City, Town or L					10d. Inside City Limits 1  Y Yes 2 □ No
uter death with the Mar rr tems 23a or 28a-f si ningr must be notified Finneral Director	a Die	6 HILLSIDE CT.			10f. Zip Code 2 1 1	57		10g. Citizen of What C	ountry?
within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28a-f show the Modical Examinations to be notified at home land has been been always to be a function.	2	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 X No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Specify: WI	ite, etc.
ad within 72 houygiena. her than "natura". t. Itte Medical E.	paraduro	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or !	(Give	DO NOT use retir	e during most of wor ed)	king	16b. Kind of Busines	·
12 should be fitad within: n and Mental Hygiene. r is marked other than " reumatic event, the Med	מ			BLIZZARD		18. Mother's Nan	JEAN C	, Maiden Sumame)	10.10
permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once.  To Re Commissed by Europea Difference.	-	19a. Informant's Name/Relationship (T)  PATSY J. BLIZZA  20a. Method of Disposition  1 □ Burial 2√□ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)	ARD - MO	THER 134	7 BREHM osition (Name of	RD., WE	ESTMINS Date	STER, MD 2 20c. Location - City of SYKESVILL	21157 r Town, State
permit. P Departme Importan any injur		21. Signature of Funeral Service Licens	That	2 2	2. Name and Add	ress of Facility FL	ETCHER , WEST	FUNERAL MINSTER,	·
Cate be executed by sician and hysician and the burial-transit the burial-transit chiral Examiner	ai Examiner	23a. Part1. Enter the it ease, or son o shock, or heart filure. List hip of shock, or heart filure. List hip of shock, or heart filure. List hip of shock or condition resulting in death)  Sequentially list conditions, if any, loculing to minimodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):  a consequence of):  a consequence of):		BETES DENCE AL EV			Interval Between Onset and Death
death certific e attending p ed for use as	iysicianimedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnan ⊒ Other (specify)	су		23d. Date of d Month	alivery Day Year
law requires that the as been signed by the 2 should be detache	d by Fr	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying cause g	given in Part I.		tobacco use contribute Yes 2 □ No 3 □	to the cause of death? Probably 4 □Unknov
: The law require cate has been si page 2 should I	Complete						24a. Was auto perfo 1 🗆 Yes	psy prior to ormed? death?	autopsy findings availab completion of cause of s 2 \( \sum \text{No} \)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Re Comm	2	27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	4	of 28c. Inj		lome 5 Resi	one) idence 6 □Other (Sp how injury occurred	ecify)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Attert completely filled in by the funeral Madical Certification:	Certificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, s ic. (Specify)				(Street and Number or I wn, State)	Rural Route Number,
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical	(Check only 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	f examination and/or i	nvestigation, in my	opinion, death occu	e, and due to the irred at the time,	cause(s) and manner and date and place, and de	ue to the cause(s)
withi To t		29b. Signature and title of certifier  30. Name and address of person who c	ompleted cause of	de <b>a</b> th (Item 23a) (Type		nse number PODGH - VSPER	39	29d. Date signed (Mod S/6)	nn, Day, Year)
State Registrar	e	31. Date filed (Month, Day, Year)	NE-TON	rar's Signature	Es man	V57ER	mo	2457	

State Registrar

31. Date filed (Month, Day, Year)

08

2007

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

**ORIGINAL** 

3001 SHANOVER ST. BALTIMURE, MD

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

echan McCarg		1- For State Registrar  Gratificate of Death		ı. No.	
Physicia	an/	1. Decedent's Name (First, Middle Last)	2. Date of Death		3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution, give street and number)  4 b. City, Town, or Location of Death	Month I August 2, 2	007 4c. County of Death	0807 hrs
•		Johns Hopkins Bayview Medical Center Baltimore		N/	/ *
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	_	(MM/DD/YYYY) 9. Bir Foreig	
Director		216-16-16-11 1VM 2 F 29 Yrs.	January		untry) MD
ану		Usual Residence of Decedent  10a. State	/		10d. Inside City Limits
<b>*</b> .	ĕ	MD N/A Baltimore  10e. Street and Number 10f. Zip Code			1 Yes 2 No
Maryl r 28a-f ed at o	Director		10ς	g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho		1903 Crestyiew Road 21239  11. Marjtal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	necify Yes or No-	USA 14 Page - Amer	ican Indian, Black,
death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		White, etc.	Frican
s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 V No specify:		Specify:	nexican
hin 72 hours afte e. than "natural", edical Examiner	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the pro		16b. Kind of Business/	
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21215-0036 Duld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)  18. Mother's Name	, ,	/	
212 ould be Menta marke	ro Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or F	Rural Route Numb		e, Zip Code)
n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland realth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once		Hermanione Mc ango /muther 1903 Crestview R 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	oul But	Homone MD	21239
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Ms		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Itim it. Pag rtment ortant: y or of		4 Donation 5 Other Specify  21. Signature of Funeral Service Libraries  22. Name and Address of Facility	11/07	Daltimone	Conty, MD
Balti permit. Departn Imports injury o		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify 21. Signature of Tuneral Service Libratee  22. Name and Address of Facility 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify 22. Name and Address of Facility 4 Removal from State Crematory or other place) 4 PA P Service Libratee	ain Roa	I Sewici	90212 am se
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical .xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):			Death
he.		Sequentially list conditions,  b			
	Examiner	if any, leading to immediate Cause. Enter Underlying Cause			
ed ssit	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
'60, rate be executed physician and re burial - trans		UNPENDED AMENDED	·		
	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	y
certific	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific)	ancy	Month I	Day Year
Box 687  The death certification is the attending properties of the asternation is the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the s	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Specify)			
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e law r e has b ge 2 sh	Completed		autops	ned? death?	completion of cause of
Vital Reco	Be Co	25. Was case referred to medical 26.Place of Death (Check	1 Yes 2	No 1 Y	es 2 No
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risio r Atten er deat irector of by the	ertification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	reet and Number or Ru	ural Route Number, City
Division spital or Attenc ours after death neral Director:	Certi	3 Suicide 6 Could not be determined (Specify) Local Street in Vehicle	or Town, Sta 3700 Lyndale A	ate) Avenue, Baltimore, M	ИD
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To the To the To the Comp	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number	Te and armo, date di	29d. Date signed (Mo	
~		Allina Brassell otto		August 3, 2007	
in The		30. Name and address of person who completed cause of death (Item 23a)			
, )		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD  31. Date filed (Month, Day, Year) 32. Restrar's Signature	21201		
St Regist	ate trar	31. Date filed (Month, Day, Year)  AUG 0 8 2007			
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DHMH 17 Rev 1/2001

State Registrar 11065

Little Patoxent Pankway Columbia MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

31. Date filed (Month, Day, Year)

U KK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MULLINS 0310 AM CHIRLEY August 03 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Columbia County Henren Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 X F Months Days Hours 212-34-0921 71 January 14, 1936 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Maryland Howard Columbia Directo 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21045 8746 Tamar Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: 2 White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Beavers Otto Sizemore ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8746 Tamar Dr. Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type. Print) Daughter Ms. Jean Coffiell nt of Health : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Scremation 3 R

4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State 3 ☐Removal from State 08/07/07 Baltimore, MD Department of Important: If any Injury or **Bayview Crematory** 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Licensee MO1292 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac arrest due Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): artery disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown has been sig ge 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No s certificate ha lirector, page 2 1☐ Yes To the Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ the funeral dir 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Director (illed in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 25. one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DU053709 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant FUX CHAWLA STE # 210 Bowle A

Registrar

State

31. Date filed (Month, Day, Year)

AUG 8

ORIGINAL

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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		For State Registrar	State of Ma	aryland /		tment of H <i>ificate of I</i>		, ,	giene Reg. No.	007	
Physic	ian	Decedent's Name (First, Middle, Last	st)	-	I	)		2. Date of Dea	ath Day	Year	3. Time of Death
/Medi	cal	tva	a street and number!			inder	Lacetian of Deeth	Augus		2007	18:10 PM
Examination Funeral Director	ner	5. Social Security Number 6. S 212-26-1395	PKINS HOS	e (In yrs. last	birthday)_	Honder 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct.	h v, Year)	Coul	place (State or Foreign htry) yland
/land low at		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loca	ation				1	10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2√ N If Yes, Give Year or Dates:	No		Yes, specify Cuba □Yes 2√⊑No	ispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Black, White, ecify:	
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d be fi	Be C	17. Father's Name (First, Middle, Last)  Charles W. Wel					18. Mother's Nam	e ( <i>First, Middie,</i> a Hornur		name)	
should and Me mark umariid	2	19a. Informant's Name/Relationship		1	9b. Mailing	Address (Street	and Number or Ru			own, State, Zip	Code)
and 2		Mr. William F. P.	inder, Jr.	(Son)	1003	Irwins	Choice	Bel Air,	Mary	land	21014
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I or Atter after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc		farm, stree	et, factory, office		28f. Location (S City or Tox		umber or Rura	al Route Number,
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical C	29a. Certifier  (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	ige, death and/or inve	occurred at the tirestigation, in my o	me, date and place	, and due to the rred at the time,	cause(s) and date and pla	d manner as s ace, and due t	otated. o the cause(s)
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Sta Regist		31. Date filed (Month, Day, Year)	he Johns	HOPKIV ar's Signature	is Hoc	spital, 40	O North W	loife Street	et, Balti	imore, M	aryland 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** AUGUST 02:08 M al 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL Baltimore JOHNS IDPKINS 1 Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 21 F 213 54 2693 Director 81 MAY 6,1926 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he matified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD. Director N/ABALTIMORE CITY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4613 LUERSSEN AVE. 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ģ 3 ₩idowed 4 Divorced BLACK Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ROSETTA ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) great TIMEKA HOWARD 21206 BALTO, MD. 4613 LUERSSEN AVE. niece) 20b. Place of Disposition (Name of cemetery, crematory or other place)

AUG. 8, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Defration 5 ☐ Other (Specify) GREEN MOUNT CREMATORY BALTO, MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1412 E. PRESTON ST. BALTO, MD. Approximate Interval Between Onset and Death DISSEMINATED Immediate Cause (Final disease or condition resulting in death) **Physician** INTRAVASCULAR C OAGUL dal /Medical Due to (or as a consequence of): Examiner PULLUDNAP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner SUPSIS The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident the Funeral Director: pletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number MEDICAL DOCTOR

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

HOPKINS JUSPITAL, 600 NOPTH WOLFE STREE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Department of Health and I  1- For State Registrar  Certificate of Death		iene	25373
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Deat		3. Time of Death
E	/Medic	al	Anthony R. Kogers  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deatl	Hug	4c. County of Death	1678 M
	Examin	er	1914 Footherbed Lane Woodlawn		Balto.	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day,	Year) / Loui	place (State or Foreign ntry)
1	Director		Usual Residence of Decedent	1-1-1	95) Ma.	ryland
	ryland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma	ecto	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	
	3 or 3	וֹם	1914 Featherhed Lane 21207		4.5.	A.
	ems 2	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No   1 ☐ Yes 2 ☐ No   Specity:   3 ☐ Widowed 4 ☑ Divorced   Year or Dates:		Specify:	a c/c
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow disal Examinat must be rediffed at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	rkina	16b. Kind of Business/Ir	ndustry
21	within 7 ene. then "r	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	1	T . + . 5	
d 21	Hygier ther the			me (First, Middle, I	Maiden Sumame)	al
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural," or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinating the rolling at ance.	To Be				1
Aary	2 should and Men Is marks		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			
	Health Health tem 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Date U	20c. Location - City or T	own, State
mol	Pages nent of int: If Its try or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	-2007	Balto. Wa	l,
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee 22. Nameyand Address of Facility	ass Fune	ral Service	P.A.
00	20729		23a. Part 1. Enter the disease, or complications that days ed the death. Do not enter the mode of dying, such as cardia.	t. Balt	s. Mg. 212	Approximate
ı	Dharistan		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	. 100	.0000	Interval Between Onset and Death
	Physician /Medical		disease of condition resulting in death)  a. Hrtoniosclostic Cantiousse  Due to (or as a consequence of):	4101 13	(Second	
£.	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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9 x	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	rery
Box	death e etter id for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		Month	Day Year
P.0	thet the deaned by the endeaned for	Phys	9 Unknown	220 Did tol	pacco use contribute to	the cause of death?
ds,	signed by det	þ	Fait ii. Other significant continuous continuous to death but not resoluing in the underlying cause given in rate.		es 2 No 3 Pro	
Records,	ne law require s has been sig ge 2 should b	jete		24a. Was a		opsy findings available
Re	The la	Completed		autops perform		ompletion of cause of 2500
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ath (Check only on	θ)	
of	Physic r this c	1: To	1 inpatient 2 ENOutpatient 3 DOA 4 Nursing i		ence 6 Other (Speci ow injury occurred	ify)
ion	ath. rr: After	atior	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division	or Attending ster death. Director: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	reet and Number or Ruin, State)	ral Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page			e, and due to the c	ause(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time, d	ate and place, and due	to the cause(s)
	To the within To the comple	X	111	2	9d. Date signed (Month)	, Day, Year)
		<	30. Name and address of person who completed cause of death (lem 23a) (Type, Print)		Hugus T 6	1500/
	8		Philip Militelle, MD 6 Trimble Hill CT. Luth	env: lle	MDZ	1093
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 8 2007		,	

<b>,</b> .			
State of Maryland	Department of He	ealth and Menta	l Hvaiene

narquett Riddick			tment of Health and Mental H ficate of Death			
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	neate of Beath	Reg 2. Date of Death		3. Time of Death
Medical Examir		Marquett Riddick		Month [ July 6, 2007	Day Year	0955 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
		Bowie Health Center	Bowie	·	Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24Hrs  Nonths Days Hours Min	_		gn DC ountry)
	-,	Usual Residence of Decedent           10a. State         10b. County         10c. City, To.	own or Location			10d. Inside City Limits
<u> </u>	٦	DC Wa	shington	· ·		1 Yes 2 No
Aaryland 28a-f show 1 at ouce.	Director	10e Street and Number 5202 Central Ave.	10f. Zip Code	_ 10g	. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at ouce.		3202 Central Ave.	20019	114	USA	
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? X	<ol> <li>Was Decedent of Hispanic Origin? (S         If Yes, specify Cuban, Mexican, Puerto     </li> </ol>		14. Race - Ame White, etc.	rican Indian, Black,
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify: B1	ack
urs aft	à	or Dates:	6a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business	/Industry
5 72 ho m "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)		
5-0036 ifed within 7 Hygiene. I other than the Medica	희	. 0	NA	e (First, Middle, Ma	NA	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last)  Marquett Tyler	Robin	Ridd		
2121 2121 Judd be fill Mental H marked ic event,	10.8	19a. Informant's Name/Belationship (Type, Print.) RODIN RICCICK/ Mother	19b. Mailing Address (Street and Number or	Rural Route Numb	er. City or Town. Sta	e, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once			5202 Central Ave.			
re, s 1 and f Heal If item			ace of Disposition (Name of cemetery, ematory or other place)		20c. Location - City of Landover	
Pages Pages ment of			monte Mom Dawle			•
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		21. Signature of Funeral Service Ucensee	22. Name and Address of Facility Rot 108 W. North Ave	natu ta	timore	гп MD 21201
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. I				Approximate Interval
/Medical		failure. List only one cause on each line.	cerebral maldevelopment			Between Onset and Death
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	_	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
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that the detached	Y P	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.			o the cause of death?
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tal Recition: The certificate	a	25. Was case referred to medical examiner?	26.Place of Death (Check		Residence 6 Oth	
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Di Hospital 24 hours a Funeral J	Certification:	4 Homicide determined (Specify)		or fown, ou		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and manner stated.	e, death occurred at the time, date and place, an d/or investigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as st nd place, and due to	ated. the cause(s)
E 3 E 3	Re	29b Signature and title of certifier	29c. License number		29d. Date signed (N	fonth, Day, Year)
		(Calulesta)	O.C.M.E.		July 7, 2007	
0		30. Name and address of person who completed cause of death (Item 2 Laron Locke MD. Assistant Medical Examiner	<sup>(3a)</sup> 111 Penn Street, Baltimore, MD 21	201		
St Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 0 8 2007  32 egistrar's Signatur	bout	-		
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			State of Maryland / I		artment of H		Иental Hy	giene	)	
			Registrar	Cer	lilicate of t	Jeam	2. Date of De	Reg. No.	200	O Thurs of Floority
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Month	Day	and the second	3. Time of Death
	/Medic		MARY L. ROTHMAN  4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death	MUGUS	40	County of Deal	h
Ĺ	Examin	er	GILCHRIST CENTER		TOWSO		1		BALTIMO	
н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign
Ė	Director		213-32-4191   1 M 2 F   71  Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	04/0	4/19	936 NE	VORK
	land ow It		10a. State 10b. County 10c. City, Tow	vn or Lo	cation					10d. Inside City Limits
	Mary I-f sh fied a	tor	MD CARROLL LINE	BOF	80					1 ☐ Yes 2 No
	th the or 28; e not	jrec	10e. Street and Number		10f. Zip Code			10g. Cit	izen of What Co	ountry?
	23a oust b	Funeral Director	5308 SHAFFER MILL RD.		2110	2		US	SA .	
	tems ter m	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	)-	<ol><li>Race - Ame Black, Whit</li></ol>	
0000	urs afte al", or t Examin	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 💢 No	Specify:			Specify: WI	HITE
ה ה	72 ho natur dio i	eted	15. Decedent's Education 16a (Specify only highest grade completed)	a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor	king	16b. K	ind of Business	Industry
7 7	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medio-I Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired RETARY	1)		SE	ECRETAI	RY
2	be filed htal Hyg ed othe event,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	, Maiden	Surname)	
	should b and Menta s marked umatic e	ToE	MICHAEL RUBENSTEIN			MARY S	SCHWAR	Z		
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5	iges 1 nt of H if ite or ot		II Iburiai 2 Mcremation 3 Linemoval rolli State I		sition (Name of natory or other place	1			ocation - City or	
baltimor	it. Pa intmer intant: injury		4 □ Donation 5 □ Other (Specify) GREEN  21. Signature of Funeral Service License		OUN'T CRE  2. Name and Addre		08/08,	707	BALTO	CITY, MD.
מ	permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other?		21. Squattle of Futbal service Licenses	HE	NRY W.	JENKINS	S & SOI	NS C	20. 21111	
ľ	10.11		23a. Part1. Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
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200	quires n sign Ild be	d by					1 🗷	Yes 2	□ No 3 □ P	robably 4 □Unknown
္ပ	law rec as beer 2 shou	lete					24a. Was	s an	24b. Were a	utopsy findings available
H H	The ate h page	Completed					auto perf 1∐ Yes	psy ormed? 2 ☑ No	death?	completion of cause of 2 □ No
II al	Physiclan: this certific ral director,	Be (	25. Was case referred to medical examiner?		Lau	26. Place of Dea	ath (Check only	one)		1.5
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ISION	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, f	farm, str		763 2 1140	28f. Location	(Street a	nd Number or R	ural Route Number,
2	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	•			City or To			,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	edical C	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my knowledge 2☐ Medical Examiner: On the basis of examination a and manner stated.							
	omple	Med	29b. Signature and title of certifier		29c. Licens	e number		29d. Da	ate signed (Mon	th, Day, Year)
)	- > F 0		M Bathus Kiling, in	ور	100	2520	5	Av	GUET 6	5,2007
	O		30. Name and address of person who completed cause of leath (Item 23a)	) (Type,	Print) A//	Charle.	F 1	la i	Oh m	1 7020

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** <u>12:</u>20 a<sup>M</sup> ELEANOR AGNES STEWART 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS-DULANEY VALLEY BALTIMORE TIMONIUM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) DEC 28 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2×F Director 219-32-5931 73 1933 MARYLAND Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show the notified at 10b. County 10d. Inside City Limits 1 XYes 2 No Director Maryland BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3622 W. BELVEDERE AVENUE Funeral 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2XXNo 3K Widowed 4 ☐ Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) MCVETS REHAB CNTR. College (1-4or 5+) 11th grade COOK Department of Health and Mental Hygi Important: If Item 27 Is marked other v Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tynette Robinson/Daughter 3622 W. Belvedere Ave., Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify)
Signature Fig. 12 Service i ense New Cathedral Ceme. : 08-10-07 BALTIMORE, MARYLAND 21. Signature 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE., BALTIMORE, MD. 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of respiratory arrest, shock, or heart failure. List only one cause on the failure of the cause of the failure of the cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-t Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ဥ Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) her. 8.6.07

DHMH 17 Rev 1/2001

State Registrar

000

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryland /	Department of H Certificate of L			ene (107	2530 !
			Decedent's Name (First, Middle, La	st)			2. Date of Death		3. Time of Death
	Physici		Baby Boy	Sunderland			August	1 2007	02:15A <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, giv		4b. City, Town, or	Location of Death		4c. County of Deat	
		6	Greater Baltimo	re Medical Cen	ter Tow	con		Baltim	0.77.0
	Funeral	1000	5. Social Security Number 6. S	Sex 7. Age (In yrs. last b	irthday) If Under 1 Year Months Days	Son If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	year) 9. Birth	nplace (State or Foreign untry)
	Director		unk	I⊠M 2□F	Yrs.	2 41	07/31/	2007 Ma	ryland
	pu *		Usual Residence of Decedent  10a, State 1.0b, County	10c City Tox	wn or Location				10d. Inside City Limits
	sho	5	A	A	len Burnie				1 □ Yes 2 No
	the N 28a-1	ect	MD ANNE	ARUNDEL G	10f. Zip Code		10	g. Citizen of What Co	untar?
	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or flems 23a or 28a-f show ent, the Mudical Examiner must be molified at	Funeral Director	128 Janelin Dri	70	2106	1	.   "	USA	unity:
9	leath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hi		ecify Yes or No-	14. Race - Ame	ican Indian.
	r Iten	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
ř	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No	Specify:		Specify: Wh	nite
9	72 ho	ted	15. Decedent's E (Specify only highest gr.		a. Decedent's Usual Occupa (Give kind of work done of	ition	1	6b. Kind of Business/I	ndustry
21	Ban "	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired,	)	''y		
2	ed wi	Completed	0	0	Infant			Infant	
<u>n</u>	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last			18. Mother's Name			
<u>¥</u>	should be nd Mental marked o	은	Sean	Sunderlan			C. Scri		-
Maryland 21215-0036	and rand		19a. Informant's Name/Relationship	Type, Print) 19	b. Mailing Address (Stre. t	nd Number or Rura	al Route Number,	City or Town, State, Z	1D 21204
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Mudical Examinat must be notified at ance.	1 8	20a. Method of Disposition	MOVOY O	of Disposition (Name of	MINUES	Date 2	Oc. Location - City or	Four State
altimore,	Pages nent of B int: If ite		1 Burial 2 Cremation 3	Removal from State cernete	ery, crematory`or other place	a)	2	-	
	t. Pa rtmer rtant rjury		*4 □ Donation 5 □ Other (Special		NAMT	1,		BALTIMOR	
Ba	permit. Departr Importe any inju		21. Signatur of Fundral Service Lice	1588	22. Name and Addres	S OF Facility	4		ino Sous Co.
			22a Part 1 Enter the disease or com	plications that caused the death. Do	and anter the and of duine	cuch as cardiac		to MD	2 ((()
			shock, or heart failure. List only	one cause on each line.	not enter the impde or dying	, such as cardiac o	n respiratory arres	51,	Interval Between Onset and Death
П	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a expresse	- frem	april	4		2hr 41 min
	Examiner			Due to (or as a consequence	of):	,	J		
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):				
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
<u>,                                     </u>	exec in an	Еха	resulting in death) Last	Due to (or as a consequence	of):				
8760	icate be executed physician and s the burial-transit	dicai	(	d					
9	rtifica ng ph as th	Ned	IC CEMALE.						
Š	eath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3 Ectopic pregnancy			23d. Date of deli	
). B	e dea the at ned fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			Month	Day Year
л. О.	that the de ted by the a detached f	Phy	Part II. Other significent conditions	contribution to death but not conulting	in the waderhier equal rive	n in Doct I	23a Did toho	cco use contribute to	the cause of death?
	gr gr	þ	Part II. Other significent conditions	contributing to death but not resulting	in the underlying cause give	miiraiti.	1 🗆 Yes		bably 4 Unknown
Records,	w requir been si should	Completed							
ě	has by	ldu					24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
<u> </u>	(0						1 □ Yes 2	No 1 ☐ Yes	2□ No
VITal	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	utpationt 30 DOA Othe	26. Place of Death			
	Phys this al di	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Ainpatient 2 EH/O	dipatient 3 DOA	4 Indising no	me 5 Resident 28d. Describe hov	ce 6 Other (Spec	ify)
Division of	ding I h. After funer	tion	1 ⊋Ñatural 5 ☐ Pending	(Month, Day Year)	Injury Work	? 'es 2 □ No	200. 2000.120 1101	injury cocurred	
S	l or Attendater death Diractor: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not b	e One Diese of Injury At home f			28f. Location (Stre	et and Number or Ru	ral Route Number,
2	after Dirac	erti	4 Homicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,	State)	
	To the Hoscital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			ysician: To the best of my knowledg					
	ne Ho 7 24 l ne Fu detely	Medica	(Check only 2 Medicel Examone)	niner: On the basis of examination a and manner stated.	nd/or investigation, in my op	inion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	,	29c. License	number	29	d. Date signed (Month	. Day, Year)
			> 1 Mbc	سعس	D005	0550		08/01/2007	7
			30. Name and address of person who	completed cause of death (Item 23a)					
				D. 1205 York Road	- Suite 14	Luthervi	lle, MD	21093	
	Sta		31. Date filed (Month; Day, Year)	32. gatrar's Signature	la de				
	Registr	ar	AHG 0.8 2	111/ Dadies of	CHARLES .				

Sunderland, Caby Pay

DHMH 17 Rev 1/2001

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7,35 AM /Medical 4c. County of Death Examiner MA Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b County 10c. City Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? пs 23a or Funeral 14. Bace "natural", or items dical Examiner mu 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11 Marital Status Black, White, etc. 1 □ Yes 2 ¶ If Yes, Give ¶ Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 4 Divorced Be Completed by 3 Widowed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 7 is ⊡arked other than "natu trau⊓atic event, the Medical Hind of Business/Industry Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) ပ permit. Pages 1 and : Department of Health Important: If item 27 any injury or other tr. once. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Juneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** METANTA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29b. Signature and title of certifier

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

2



State Registrar

			1 - State Registrar	State of Maryla		rtificate of			Reg. No.	1	
	Physici	an	1. Decedent's Name (First, Middle, Last)  ELIZABETH KEY S	OMITODON 17	ODGEGE	ED		2. Date of Dea Month AUGUS	ath Day	2007	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s	treet and number)			or Location of Death		4c. County		09:30 pm
	Examin	ei d	Saint Joseph M	Tedical Ce	nter		Tows	on		Balt	imore
\	Funeral Director		219-03-7991	7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 05/20/	, Year) 1915	Cour	place (State or Foreign htry) YLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation	<u> </u>				10d. Inside City Limits
	e Mary la-f sh tifled	ctor	MD BALTIMOR	E I	MONKTO	N					1 ☐ Yes 2 No
	th with th 23a or 26 Ist be no	Funeral Director	10e. Street and Number 1904 CORBRIDGE	LANE		10f. Zip Code 2 1 1 1 1			10g. Citizen of USA		ntry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1  1 □ Never Married 2 □ Married 3 □ Widowed 4 👿 Divorced	Was Decedent Ever in Armed Forces?     □ Yes 2		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Bla	ce - Americ ck, White, <sup>fy:</sup> WHI	etc.
21215-0036	2 hour latural ical Ex	Completed by	15, Decedent's Educ (Specify only highest grade	eation	16a. Dece	dent's Usual Occup	pation during most of wor	dina	16b. Kind of B		
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	filed v Hygie other t ent, th	e Co	17. Father's Name (First, Middle, Last)		KEC	EFITONI		ne (First, Middle,			ш
/lan	should be ind Mental marked o	To Be	PINCKNEY L. SOT	HORON			CORINN	E WILL	AMS_		
Maryland	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type ROBERT O.C. WOR			-	and Number or Ru				,
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro			osition (Name of matory or other pla		Date	20c. Location	•	•
	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fungral Service License	GI	REEN M						ITY,MD.
ğ	perm Depa Impo any i		Signature of Villa Service Location	uff	 ที่	ENRY W.	ess of Facility JENKIN RK RD M	S & SON	IS CO.	1111	
	Physician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	PNEUMONI	eath. Do not en						Approximate Interval Between Onset and Death DAYS
	Examiner			Due to (or as a cons	equence or):						
7	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
ת ה	rificate be executed og physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
68/60,	ate be hysicia the bu	ledical	d								
O. Box 6	n requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3[	⊒Ectopic pregnanc ⊒ Other (specify) _	y			ate of deliver	ery Day Year
J.	s that the ned by detact	by Ph	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
Space	equire en sig ould be							1 🗆 Y	es 2 No	3 ☐ Prof	bably 4 ☐Unknown
Hecords,	sician: The law requires that certificate has been signed b irector, page 2 should be deta	Completed						24a. Was autop	an 24b. ssy rmed? 2 No	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Vital	sian: ertifical ctor, p	Be C	25. Was case referred to medical examiner?					1 Yes ath (Check only o			2 110
20	rding Physician: h. After this certifica funeral director, p	ို	1 ☐ Yes 2 No H	ospital: Impatient 2  28a. Date of Injury	ER/Outpatier	" 0 DOX		lome 5 Resid			fy)
	Attending r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Wo	rk? ]Yes 2 □ No	200. Describe in	low injury occu	ileu	
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, str ecify)	reet, factory, office		28f. Location (S City or Tow	Street and Num. vn, State)	ber or Run	al Route Number,
	e Hospi 24 hou e Funei letely fill	Medical	29a. Certifier 1. Certifying Phys (Check only one)	sician: To the best of my k ner: On the basis of exam and manner stated.	nowledge, deat ination and/or in	h occurred at the to estigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place	anner as s , and due t	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0		29c. Licen:			29d. Date signe	ed (Month,	Day, Year)
}			• (Oballo	n, my		D25	886		aug 1	5	200t
	12		30. Name and address of person who co			Print) R DRIVE	. TOWSO	N. MARY	() /LAND :	2120	4
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Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 0 8 2007

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6. 2007 Month Day Ronald Alvin Weiss 9:45A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **X**□M 2□F Months New Jersey May 4, 141-30-7261 71 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 🏖 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Briarcliff Lane 21014 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Aerospace & Defense College (1-4or 5+) Elementary/Secondary (0-12) Manufacturer Physiologist 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph Ferdinand Weiss Alice Louise Licsauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Patricia Weiss / Wife 119 Briarcliff La., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 8-8-07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Horsell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC DISFUNCTION 3 DAYS Due to (or as a consequence of):

**Physician** /Medical Examiner

Health tem 27 I

Department of H Important: If ite any Injury or ot

**Physician** 

Examiner

**Funeral** 

Director

or 28a-f show e notified at

ral", or Items 23a or Examiner must be

Director

Completed by Funeral

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Examiner

hysician and the burial-transit Certification: To Be Completed by Physician/Medical attending p signed by the a sate has been signated bage 2 should be After

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	CARDIOMYOPATHY	10 YEARS							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):								
resulting in death) Last	Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1								
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown							
		. Was an autopsy performed? Yes 220 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 250 No							
25. Was case referred to medical examiner?	26. Place of Death (Check								
1 Yes 25 No	Hospital: ↑ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)							
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No	cribe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At nome, farm, street, factory, onice 28f. Loca	tion (Street and Number or Rural Route Number, or Town, State)							
	ysician: To the best of my knowledge, death occurred at the time, date and place, and due								

ah State Registrar

within 24 hours after death

To the Funeral Director: of completely filled in by the f Hospital

To the

Medical

one

29b. Signature and tit

**JEFFREY** SELL

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

MID

M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32 Registrar's Signature

29c. License number

D38570

31. Date filed (Month, L 0 8 2007

of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 29c,30, perDVR, g870, 8/8/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician August 714 AM Ider 5 2007 /Medical 4a. Facility Name (Wast Institution, give street and number) 4c. County of Death Examiner Randallstown Baltimore Northwest HOSPITA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2□ F 12/28/1945 109-34-2111 61 NY Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 FOX FIRE COURT 21042 U.S.A. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 🎇 No WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 DIRECTOR OF EDUCATION WINE & SPIRITS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TOMBERG FRANK WILDER WANDA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBI WILDER / WIFE 2907 FOX FIRE COURT - ELLICOTT CITY, MD 21042 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition LAKEVIEW MEMORIAL PARKO8/07/2007 SYKESVILLE, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Malt Leunse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s certificate To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ FB/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66171 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) CIM MO Northwest Hospital Randallstown, MD

State

Registrar

32 Registrar's Signature

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** illiam 0:15 A.M FOOG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia seneral Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 KF Months Days Hours 64 223-62-2185 Portsmouth, Virginia December 3, 1942 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Howard Clarksville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 21029 U.S.A. 13110 Greensberry Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: <u>م</u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other trailmatic. Elementary/Secondary (0-12) College (1-4or 5+) Design Designer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie V. Vick Shirley L. Hanbury ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13110 Greensberry Lane Clarksville, Maryland 21029 Mr. Robert Williams Husband 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 08/01/07 Sykesville, Maryland All County Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer WIZGZ 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that cause \* he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 8 HOURS MYCKARDIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate basis. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ icate has been sig , page 2 should b 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an certificate 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 SER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Hospital or Attendii 24 hours after death. Funeral Director; A 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Way

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARKSON, mm

Year)

5540 THU DAKI RD,

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Calvert Walker, Sr. 10:20 a. M August 5, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel 588 Glen Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Country Months Days Min 67 218-36-6295 1 1 2 F November 21, 1939 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 No a or 28a-f she be notified a Glen Burnie Director Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 588 Glen Court items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 🖈 No Baltimore, Maryland 21215-0036 Specify. Specify. þ White 2 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M Carpentry Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva May Lowe John Calvin Walker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Warwickshire Lane Apt. H. Geln Burnie, Maryland 21061 Daughter Ms. Clister Veal Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 08/09/01 Baltimore, MD **Bavview Crematory** 22. Name and Address of Facility
Slack Funeral Home, P.A atrire of Funeral Sen 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NON-DWALL O MOUTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IE EEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) gaughters 2X No Hospital: Other: 4 Nursing Home 5 Residence 1 🔲 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ٩ 6) Other (Specify) COLUC this 28h Time of 28a Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director; / d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

of death (Item 23a) (Type Print)

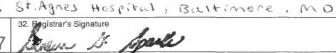
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 8:35 AM 2007 Howard James Younger Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Agnes Hospital Baltimor 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 11 M 2 □ F 7, 1919 Director Maryland 215-18-8356 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 1 No Director Catonsville Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 912 South Rolling Road 21228 USA death v Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3X Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. **7 is marked other than "**' Elementary/Secondary (0-12) College (1-4or 5+) Printer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvena (unk) Rezac Howard James Younger or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trauonce. 4628 Old Dragon Path, Ellicott City, MD 21043 Howard J. Younger III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8-2-07 Bel Air Memorial Gdn Bel Air, Maryland 21. Signature f Funeral/Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final respiratory Failure **Physician** Hypoxic disease or condition resulting in death) 5 days /Medical Due to (or as a consequence of): Examiner s days Aspiration pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Severe dementia 5 years Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2☐No P.O. ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 No 3 Probably 4 Unknown Hypo thyroidism 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Prostate cuncer 24a. Was an page 2 s autopsy performed certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital within 24 hours a To the Funeral I 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Lounger

31. Date filed (Month, Day, Year) State Registrar

900 S. Caton



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paracston Facella, MD

Farel , MO

AUR,



OP19513

July 31, 2007

21229

te of Maryland / Department of Health and Menta	l Hygiene
Certificate of Death	Reg. No.

Physician	
/Medical	
Examiner	

with the Maryland ral", or Items 23a or 28a-f show Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examinan

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day MARIAN ABRAMS 3:58 P AUGUST 3. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPTIAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/18/1918 6. Sex 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 🔀 F 89 Yrs Director 578-03-4031 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Directo MARYLAND MONTGOMERY GAITHERSBURG 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 413 STONEMASON DRIVE 20878 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2DXNo Specify: WHITE δ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISRAEL BARKER IDA KAUFMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK ABRAMS/SON 413 STONEMASON DRIVE, GAITHERSBURG, MARYLAND 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 32 Removal from State KING DAVID MEML GDNS 108/06/2007 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 21. Signature 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. John 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 hours Due to (or as a consequence of): spirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for selectoresquence of: neumanio Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1003 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 4100 2□ No Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006452 AUGUST 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND BRIAN CARPENTER, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature **AUG 0 8 2007** Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 2007 IRVING ALPER AUGUST 10:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME POTOMAC MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11 M 2 □ F Yrs. 93 OCT 6, 1913 NEW YORK Director 053-10-9673 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 28a-f sh notified tx∏Yes 2 □ No Directo MARYLAND MONTGOMERY POTOMAC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 22 SANDALFOOT COURT 20854 'natural', or items 23a dical Examiner must t U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 ∐**xi**No Specify: WHITE Specify: <u>Ş</u> 3₺ Widowed 4 Divorced Completed r than "natur, the Medical B 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR STATIONARY & PRINTING Item 27 is marked other other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YETTA "UNASCERTAINABLE" ELIAS ALPER ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau JOEL R. ALPER - SON 22 SANDALFOOT COURT, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 08/06/2007 | MENORAH GARDENS 4 ☐ Donation 5 ☐ Other (Specify) NORTH MIAMI BEACH, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, 20852 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed POSSIBLE ASPIRATION PNEUMONIA physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical DEMENTIA attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death ned by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has lirector, page 2 s autopsy performed? 1∐ Yes 2 🗓 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4√∑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ∑No 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 □ No 1 ☐ Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-20274 AUGUST 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KIRTI VOHRA 7710 BRADLEY BLVD, BETHESDA, MARYLAND

State Registra

AUG 08

31. Date filed (Month, Day, Year)

32 Registrar's Signature

07-05751

Ha

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arry Lester Angle,	State of Maryland / Depa 1-For State Cer	rtment of Health and Mental Hy <i>tificate of Death</i>	Reg. No.	2 1 2 to to a			
	Registrar  1. Decedent's Name (First, Middle,Last)	imodic of Bodin	2 Date of Death	3. Time of Death			
Physician/ Examiner			July 26, 2007	2038 hrs			
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De Washingtor	No.			
	9309 Stottlemyer Road	Boonsboro  If Under 1 Year   If Under 24Hrs					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la	Months Days Hours Min	- IFo	reign Country) MARYLAND			
Director	214-29-3605 1X M 2 F 17	Yrs.	APRIL 10, 1999	" TITAL LITAR			
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Aaryland 128a-f show 1 at once.	10e. Street and Number	10f. Zip Code	Country?				
th the Maryla 23a or 28a-f 10tified at or	9309 STOTTLEMYER ROAD	21713		S.A.			
after death with the Maryland aller death with the Maryland all, or items 23a or 28a-f she iner must be notified at once over Tuneral Director	11. Marital Status 12. Was Decedent Ever in U	S. 13. Was Decedent of Hispanic Origin? (S		merican Indian, Black, tc.			
or iter	1 Never Married 2 Married 1 Yes 2 X No	1 Yes 2 X No specify:	Specify:	WHITE			
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21215-0036 Suld-be filed within 72 hours after death Nowald Hyggene Indicated other than "matural", or ite ic event, the Medical Examiner must	HARRY LESTER ANGLE JR.						
	19a. Informant's Name/Relationship (Type, Print ) H ARRY L. ANGLE JR./FATHER	9309 STOTTLEMYER ROAD	, BOONSBORO, MAR	YLAND 21713			
md 2 salth	20a, Method of Disposition 20b.	Place of Disposition (Name of cemetery,	Date 20c. Location - Ci	ity or Town, State			
Ore ges 1 t of H : If i	1 X Burial 2 Cremation 3 Removal from State	crematory or other place)  EAVER CREEK CEMETERY 7/	31/2007 HAGERST	OWN, MARYLAND			
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Balt permit. Depart Impor injury	Paul M.	Dean BAST FUNERAL HOME	Boonsboro, Mar	yland 21713 Approximate Interval			
hysician	23a. Part f. Enter the disease, or complications that caused the deat failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or neart	Between Onset and Death			
Medical Examiner	Immediate Cause (Final disease a. Methadone and a	cohol intoxication					
	or condition resulting in death)  Due to (or as a consequence	or):					
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Box 68766 e death certificate the attending phy ed for use as the	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not		23e. Did tobacco use contrib	ute to the cause of death?			
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of Vital Recing Physician: The After this certificate inneral director, page	25. Was case referred to medical	26.Place of Death (Che ER/Outpatient 3 DOA Other,4 Nu	rsing Home 5 Residence 6	Other: Scene			
F Vit	O 1 Yes 2 No	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurre				
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Sio Atten r deatl ector. by the	2 Accident Investigation 28e. Place of Injury - A	er or Rural Route Number, City					
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Hospi 24 hou Funer tely fil							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transi	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my definition, additional and manner stated.						
H × H ō		O.C.M.E.	July 27, 20				
-	high, mod						
144	30. Name and address of person who completed cause of death (If Ling Li, MD Assistant Medical Examiner 1	tem 23a) 11 Penn Street, Baltimore, MD 21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 30 AM July Mamie Marie Barrett 2007 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11TIZENS NURSING HAVRE ORO HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 36 GRACE Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Director 214-24-3535 89 02/24/1918 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD Harkord Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 706 Beards Hill Road 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Hursing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Richard Hall Emma Oakley 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Beards Hill Road, Aberdeen, Maryland 21001
of Disposition (Name of Date 20c. Location - City or Town, State George S. Barrett (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gardens 07/30/2007 Aberdeen, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Lellman Mitchell Smith Funeral Home 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 1 Live birth 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 21 No 1∏ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury M 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be executed. Box 68760. P.O. Records. Vital Attending Physician: Division or ARK ö To the Funeral

Baltimore, Maryland 21215-0036

State Registrar

Medical

Year) AUG 08 2007

29b. Signature and title of certifie

29a. Certifier

and manner stated.

D42800 UNION AUL., Hd6,

cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician 11:15 AM Dary Jest 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkers rayliners are contr capture Deltisons If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days M 2□ F Director 48 578-80-0460 Oct. 15, 1958 Wash., DC Usual Residence of Decedent r 28a-f show notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 116 Paca St. 21201 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 172 h 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event \*\*\*. Elementary/Secondary (0-12) College (1-4or 5+) 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Borum, Sr. Florence Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Borum/Brother 4907 A St., SE #9, Wash., DC20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee's Crematory 8-3-07 4 □ Donation 5 □ Other (Specify) Clinton, MD 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Course (Final disease or condition resulting in death) **Physician** Due to (or as a conse u) nce of): weeks /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Hoone burial-tra Due to (or as a consequence of) physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? Yes 🏋 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 ☐ Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

within 24 hours afte

To the Funeral DI

completely filled in Registrar

State

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DO4383 34LY 16,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 HoPKINS BAYVIEWCIRCLE Cree no uph II MO BALTIMORR

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier (Check only one)

5 2007

State of Maryland / Department of Health and Mental Hygiene

				Otate of Wil		Certific				eg. No.	1	1.0023										
	Decedent's Name (First, Middle, Last)  Physician						2. Date of Dea Month	th Day	Year	3. Time of Death												
	/Medi		Lillian M. Burnette						July	18	2007	12:05AM										
	Examir						4b. City, Town, or L		4c. County													
			St. Thomas	More Nursi	no Home			Hvat	tsville	T P	rince	George's										
	Funeral				e (In yrs. lest b	irthday) If Un	der 1 Year	If Under 24 Hrs.				ace (State or Foreign										
	Director		579-26-1166 Usual Residence of Decedent	1□ M 2□XF	92	Yrs. Mont	hs Days	Hours Min.	June 25			rginia										
	and w	10a. State 10b. County 10c. City, Town or Location							10	d. Inside City Limits												
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	with th	Director	10e. Street end Number	C+ NE		10f.	Zip Code	20011	1	0g. Citizen of												
	ns 2	era	5201 - 11th	12. Was Decedent I	Ever in U.S.	13. Was De	cedent of h	20011 Hispanic Origin? (St	pecify Yes or No-		ed St e-America											
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or itams 23a or 28a-f ahow many Injury or other traumatic avent, the Medical Examiner must be notified at ance.	by Funeral	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:				Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, e											
Maryland 21215-0020	n 72 ho "natur: edical j	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	168	a. Decedent's U (Give kind of life. DO NO	work done	during most of work	king	16b. Kind of B	usiness/Ind	ustry										
212	ed withingiene.  er than  t, the M	Somp	Elementary/Secondary (0-12)	College (1-4or 5 4	+)		. Nur			Go	vernm	ent										
ng	at Hy	Bec	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	e (First, Middle, I	Maiden Surnan	10)											
yla	ould b Ment arked aric a	2	Jacob Washin	gton						Fannie Ferguson												
Mar	12 sh hand hand Ism traum		19a. Informant's Name/Relationship		1			and Number or Ru		-												
ē,	s 1 and Healt tem 27	3	Constance B. Jol 20a. Method of Disposition	inson/paugi		⊃∠∪ of Disposition (/ ery, cremetory o		1th St.,		20c. Location -	2001 City or Tov											
Baltimore,	Pages nent of P ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci					Cemetery	7/25/07	Sud	tland	MD										
aĦ	mit. partm porta y Inju		21. Signature of Furieral Service Lice	nsee A	Hinco			ess of Facility	Stewart													
<u> </u>	Depa Impo		1 John T.	Slevan	III			Benning 1			DC 2	0019										
(	Physician		23a. Pert1. Enter the disease, or comshock, of heart failure. List only	plications that caused one cause on each lin	the death. Do	not enter the m	ode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximete Interval Between Onset and Death										
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<u> </u>	ls ce dire	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/O	utpatient 3	DOA Oth	er: 4 Nursing Ho	me 5 Reside	nce 6 Oth	er (Specify)											
Division of	Attanding Physician: r death. actor: After this certific. by the funeral director.	:io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey		Time of Injury	28c. Injur Wor	y et k?	28d. Describe ho													
<u>s</u>	uttandi death. ctor: A y the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		n. At home for	M		Yes 2□No	28f. Location (Street and Number or Rural Route Number,			Douta Number										
	To the Hospital or Attanding Physician: The law within 24 hours after death.  young Funeral Director: After this certificate has gompletely filled in by the funeral director, page 2.	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	(Specify)	ami, street, iact	ory, onice		City or Town	, State)	er or Hurar	Houte Number,										
	To the Hospital or I within 24 hours after To the Funaral Diracompletely filled in the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of niner: On the basis of end manner stat	examination ar	e, death occurre nd/or investigation	ed et the tin on, in my o	ne, date and place, pinion, death occur	and due to the cared et the time, da	use(s) and ma ate and place, a	nner as sta and due to t	ted. he cause(s)										
	Vithin Compl	Z E	29b. Signature and title of certifier				29c. Licens		29d. Date signed (Month, Day, Year)													
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	(3/1		30. Name and address of person who	completed cause of de	eth (Item 23e)	(Type, Print)		. 1	111 -	×45 . L	11.0 6	007 WZOZA										
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DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 28 Day 2007 9:48 PM Burnell Bennings July 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country) April 11,1921 Arkansas Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Days Months Hours 1X M 2□ F 86 429-20-6585 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland St. Mary's Mechanicsville 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 41844 Queens Landing Road 20659 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Ž No Specify White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Chamber of College (1-4or 5+) Building Engineer Commerce 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonard Homer Bennings Ruby Yates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burnell B. Bennings / Daughter 41844 Queens Landing Road Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 2 Cedar Hill Cemetery Suitland, Maryland 4 Donation 5 Dother (Specify) 2007 21. Si mature of Funegal Service Licen 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 2 Leonardtown, Maryland 20650 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arrhythma 60 mates Cardine disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28.

The law requires that the death certificate be executed burial-tra as the nse for page 2

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

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Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me

**Physician** 

/Medical

Examiner

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Records,

Vital

Division

Benning

10 B

eral Sirector: After this certifical filled in by the funeral director. Hospital or Attending Physician: within 24 hours a To the Funeral I

> State Registrar

10062662 WU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Bex 524 Leonardian Mil zegozenski natthen

28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) JUL 9 0 2007

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

6 ☐ Could not be

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Douglas Laird Brown 2007 22 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY MEDICAL Wicknico REGIONAL ENINSULA STON 3. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 48 216-70-2230 Director 5/6/1959 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Wicomico 1 Yes 2 No by Funeral Director Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 228 Maryland Ave., Apt. 4 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 City of Salisbury Fireman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon L. Brown Barbara Bailey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamela J. Brown/ex-wife 900 W. Schumaker Manor Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/26/07 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park 21. Signature of Funeral Service Licens <sup>22</sup> Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FAICURE - decom pensated Veeks 61161 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by alcoholism 3 Probably 4 Unknown 1 ∏ Yes 2 ∏ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: death. within 24 hours after death To the Funeral Director:

State Registrar 4 Homicide

(Check only

29b. Signature and title of cert

MIChael

JUL 2 6 2007

100 E. CAMOIL

1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1toay53

23,2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

# filed within 72 hours after death with the Maryland timore, Maryland 21215-003

	1
	В
86	
I Records, P.O. Box 68760,	The law requires that the death certificate be executed
or Vita	Physician:
Division	al or Attending
	Hospita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 **Physician** Year BROWN BERNICE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES DOCTORS HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days Min. 1 □ M 2 🖾 F 223-70-4477 56 July 14, 1951 Virginia **Director** Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 □Yes 2X No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1211 Wiley St. N.E. 20002 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. ģ Specify: 3 X Widowed 4 ☐ Divorced Black "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Randolph Shepherd Cafeteria Worker 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporant: if Item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Smith Lewis Ward ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Romney Ct. Landover, Md. 20785 19a. Informant's Name/Relationship (Type. Print) Sabrina C. Brown/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 7-30-07 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUTE MASSIUE GARIAN HICKINA Physician /Medical Due to (or as a consequence of): Examiner IA 775 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 2 🗆 No certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Honknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 3 No tal or Attending Physician: T s after death.

al Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled it 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 267710 MO

31. Date filed (Month, Day, Year) 2 6 2007

8/18 Good Luckerd, Lanham, mD. 20706 32. Registrar's Signature

ABIO DU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

P.O. Box 68760 Division or Vital Records, within 24 hours at To the Funeral D completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ori Ving 7600 Carroll Avenue, Takoma Park, Maryland ang 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1111 2 8 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

07-05591 Kofi K. Brown

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) July 21, 2007  30. Name and ad ress of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	he Ho in 24 l he Fu pletely		(Check only one) 2 Medical Exami	sician: To the best of my knowled ner:On the basis of examination ε	ige, death occu and/or investiga	arred at the time, in ation, in my opinio	on, death occur	red at the time, date	and place, and du	e to the cause(s)
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Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	187	. 18	30. Name and ad ress of person w	ho completed cause of death (Iter	m 23a)					
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ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death Day 25 DELORES BUTLER JULY 2007 7:45 a M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3205 Riva Ridge Ct. Bowie Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Days Hours 1 □ M 2 X F 226-34-1968 78 May 28, 1929 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3205 Riva Ridge Ct. 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Norfolk Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Eley Nixon Ebbie Hunter Bryant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Riva Ridge Ct. Bowie, Md. 20721 19a. Informant's Name/Relationship (Type, Print) Lisa Butler McDougal/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roosevelt Mem. Park : 7-30-2007 Chesapeake, Va. 21. Signature of Funeral Service 22 Name and Address of Eacility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Failure to Thrive disease or condition resulting in death) Due to (or as a consequence of): Parkinsons Due to (or as a consequence of): Generalized Weakness Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetai death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2X No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

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Physician

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once.

**Physician** 

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filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-tran Division or Vital Records, P.O. Box 68760, ding physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed page Hospital or Attending Physician: rector. Be 25. Was case referred to medical 1 Tes 2 X No P filled in by the funeral 27. Manner of Death Certification: 1 XNatural after death. 2 Accident 3 Suicide 4 ☐ Homicide 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ell 8 D48101 July 25, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 133 Defense Highway Suite 112 Annapolis, Md. 21401 Donna Chambers, MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 555AM KAREN SUE BAYLIS 200' /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 577-86-2781 19/ 1958 Maryland 49 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 No Director MD Howard Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8562 Storch Woods Drive Apt. 20763 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes XXNo Specify: þ Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife **⊅omestic** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack B. Sikes Nellie May Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20763 8562 Storch Woods Dr. Apt. 1C, Savage, MD David Baylis/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Downing's Cem. 7/25/2007 Oak Hall, VA 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A. 103 Linden Ave., Pocomoke, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 05.5 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Carcinoma Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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the burial-tran Hospital or Attending Physician:

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner onee.

**Physician** 

/Medical

Examiner

certificate has birector, page 2 s

within 24 hours after death

To the Funeral Director:
completely filled in by the

DN 5

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and attle of certifier

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Parmjit S. Aujla, 5632 Annapolis Rd., Suite #13, Bladensburg,

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D42580

29d. Date signed (Month, Day, Year)

7/23/2007

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	-	- 11	Registrar  1. Decedent's Name (First, Middle, Last	*)				2. Date of De	Reg. No.		3. Time of Death
в	Physici	an	JIMMY DWIGHT CRANK					Month JULY	Day 18,	Year 2007	5:17P M
43	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death			ty of Death	3.171
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42 cc	Director		5// 86 38/6	<sup>1</sup>	9 Yrs.	World Baye	Tiodio With.	JUNE 09	, 1958		H CAROLINA
	w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or	Location				. 1	0d. Inside City Limits
	darylan f show ed at	0	MD PRINCE (	CEORCES TE	мрт г	HILLS					1.∏Yes 2 No
	the 128a-	Director	10e. Street and Number	3EORGES IL.	CIL LIL	10f. Zip Code			10g. Citizen of	What Coun	
	h with		5017 ACORN DRIVE			20	748		UNITE	ED STA	TES
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13	B. Was Decedent of H		pecify Yes or No		ace - Americ	an Indian,
စ္	after or ite mine	F.	1 Never Married XX Married	1 ☐ Yes XX No		1 ☐ Yes XX No	Specify:	o riicari, etc.)		ity: BLA	
93	nours ural", if Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	10. D						
15-	"natı	lete	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retired	during most of wor	king	16b. Kind of	Business/Ind	dustry
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 YRS.		SE MANAGE	,		GOVE	RNMENT	1
d 2	filed Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)	J IND			18. Mother's Nan	ne (First, Middle,			
lan	uld be Aenta rked tic ev	To B	UNKNOWN				ROSA CRA	ANK			
Maryland	12 should be finand be finand Mental His marked of traumatic ever		19a. Informant's Name/Relationship (T)	vpe. Print)	19b. Ma	iling Address (Street	and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip	Code)
	and and a salth n 27 I		DOREEN MARTIN CRAI			' ACORN DR	IVE :	CEMPLE H	ILLS, N	1D 207	48
ore	ges 1 and 2 should be filed within 72 hours after death with the Mar t of Health and Mental Hygiene. If item 27 Is marked other than "naturar", or items 23a or 28a-f sl or other traumatic event, the Medical Examiner must be notified		20a. Method of Disposition  XIX Burial 2 □ Cremation 3 □ F	CC	lace of Dis emetery, c	position (Name of rematory or other plac	ce)	Date	20c. Location	- City or To	own, State
Ë	. Pag tment tant: jury		4 □ Donation 5 □ Other (Specify,	HAR	MONY	MEMORIAL				OOVER,	
Baltimore,	permit. Pages 1 and 2.9 Department of Health a Important: If item 27 Is any injury or other trau		21. Signature of Foneral Service Licens			22. Name and Addre MARSHALL 4308 SUIT	ss of Facility S FUNERAI LAND ROAI	L HOME O	F MARYI AND, MI	LAND, 2074	INC.
			23a. Pan . Enter the disease, or comp shock, or heart failure. List only of	lications that cause the death	. Do not e	enter the mode of dyir	ng such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. 10 h	Tre	a ncc	157				Onset and Death
Real Control	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):				-		
	Examine	_	Sequentially list conditions,	bb. Due to (or as a consequ	ience of):						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ierice orj.						
	requires that the death certificate be executed ene signed by the attending physician and hould be detached for use as the burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):			- 1			
8760,	e be e	dical E	· ·	d							
9	tificat g phy as the	ledi									
Box	death certific attending p	Physician/Me	23b. was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		3 □Ectopic pregnance	ı			ate of delive	,
	ed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de		Other (specify)			1	fonth	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown		ulting in the	underlying course aiv	on in Dort I	220 Did t	000000 1100 00	ntributo to th	ne cause of death?
	ires tha signed I I be det	by	Part II. Other significant conditions co	intributing to death but not less	iiliiig iii trie	dildenying cause giv	en in Fait i.	1 D			ably 4 ∏Unknown
Records,	w requir been si should	Completed									
360	g 5 C	npl(						24a. Was autoj	an 24b psy prmed?	<ul> <li>Were auto prior to cor death?</li> </ul>	psy findings available mpletion of cause of
a	ate ⊐		05.111					1□ Yes	2∐No	1 ☐ Yes	2□-No
or Vital		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2   1	ER/Outpat	ient 3 DOA Oth	or	th <i>(Check only c</i> lome 5 ☐ Resid			
ō	y Physer this eral di	: To	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injur	T I I I I I I I I I I I I I I I I I I I	28d. Describe			y)
ion	Attending r death. ector: After by the fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injur		Yes 2 □ No				
Division	I or Atte after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm,	street, factory, office		28f. Location (i City or Tou	Street and Nun wn, State)	nber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co	(Check only 2 Medical Exam	/sician: To the best of my know iner: On the basis of examinate							
	To the I-within 24 To the I-complet	Medi	29b. Signature and title of certifier	and manner stated.	,	29c. Licens	e number		29d. Date sign	red (Month	Dav. Year)
	Net to Con Con Con Con Con Con Con Con Con Co	-	A A	70 A.B.	to		04637		7/2	7/1	
$\Lambda$	(10)		30. Name and address of person who c	ompleted cause of door (Item	23ab (Tum	1. //			1/2	1/ /	
AL.	-112/		SU. Ivalile and addless dependent who c	ompleted cause of deast (1981)	2001 (194	only on	1	2002	7		

State Registrar

DHMH 17 Rev 1/2001

31. Date-filed (Month, Day, Year)

case i	ype of I fille in Di	aon maonaid min	21100.074.	
	State of Maryland	/ Department of He	ealth and Me	ental Hygiene

		For State eqistrar Decedent's Name (First, Middle,Last)	tificate of Death	Reg.	3	. Time of Death
Physicia Jical Exami			stro	Month July 23, 200	ay Year 7	0130 hrs
		a. Facility Name (if not institution, give street and number) SB Interstate 495, S. of River Road	4b. City, Town, or l Potomac	ocation of Death	Montgomery	
Funeral Director		6. Sex 7. Age (In yrs. la 227–51–1135 8. Sex 7. Age (In yrs. la 21	ast birthday) If Under 1 Year Months Days	If Under 24Hrs. 8. Date of Birth( Hours Min. March 2	MM/DD/YYYY) 9. Birthr 22, 198 Foreign Coun	olace (State or try) Virginia
d how any se.		,	Town or Location			0d. Inside City Limits  1 Yes 2 X No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	Oe. Street and Number 4211 Pine Lane	10f. Zip Code 22312	10g	Citizen of What Countr	y?
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f sh ent, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No Widowed 4 Divorced If Stee, Give Year		panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) specify: Mexico	14. Race - America White, etc. Specify: Hispa	
136 hin 72 hours a e. than "natura edical Examir	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4 or 5+)	16a. Decedent's Usual Occupation during most of working life.  Sales		6b. Kind of Business/Ind Automotive	dustry
21215-0036 Juld be filed within 72 Mental Hygiene, marked other than "	Be Con	17. Father's Name (First, Middle, Last) Patricio Castro Castro		18.Mother's Name (First, Middle, Ma Clementina Mora		
S P P E S		19a. Informant's Name/Relationship (Type, Print ) Patricio C. Castro/ Father	4211 Pine Lar	t and Number or Rural Route Number ne, Alexandria, V	/A 22312	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is injury or other traumatic.		1 Burial 2 Cremation 3 X Removal from State	Place of Disposition (Name of cercrematory or other place) ecinto De La Paz  22. Name and Address	08/01/2007	Jalisco, M	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each the.	> -	mmunity Funeral ( such as cardiac or respiratory arres		Church, VA  Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Head Injuries  Due to (or as a consequence of the conditions)  b	rf):		7	
	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death). Last				
60, tte be executed hysician and e burial - transit	/ledical E	d. UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, lospital or Attending Physician: The law requires that the death certificate be executed thours after death.  Increal Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant in the Live birth 4 Pregnant at time of december 1 Unknown	2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Da	ay Year
, P.O. Bores that the de signed by the be detached f	þ	Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause of	,	acco use contribute to the 2 No 3 Proba	
cords, F law requires: has been sign	Completed			24a. Was ar autops: perform	y prior to co ned? death?	opsy findings available ompletion of cause of
tal Reciant: The certificate ector, page		25. Was case referred to medical	26.Place	1 ✓ Yes 2 e of Death (Check only one)	No 1 ✓ Yes	2 100
/ita ysician us cert firecto	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2		Other	tesidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death.  eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detacl	tion: To	27. Manner of Death  28a. Date of Injury (Month, Day Year)  Jul 23, 2007	0404		ow injury occurred xed object collision	า
Division Attures after de cral Directe Illed in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Roa	nome, farm, street, factory, office t ad / Highway	or Town Str	reet and Number or Rur ate) 95 S. of River Road,	
To the Hosp within 24 ho To the Fune completely f	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled one)  2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinior	n, death occurred at the time, date a	nd place, and due to the	cause(s)
	Ň	29b. Signature and title of certifier  And the Mr	29c. Licens		29d. Date signed <i>(Mon</i>	ш, µау, теаг)
H		30. Name and address of person who completed cause of death (Iter Tasha Greenberg MD. Assistant Medical Exan		Baltimore, MD 21201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signat				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

			For State Registrar	State	of Maryla		artment of <i>rtificate o</i> i		Mental Hygi Re	ene g. No.	851.05
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Death	· ·	3. Time of Death
	Physicia		George Gus C	okas					July 21	Day Year 2007	12:01 a M
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location of Death		4c. County of Death	12.01
<b>*</b>	-Aumin		Montgomery Gen	eral Hosm	nital		Olr	VA		Montg	omeru
-	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Yea	r If Under 24 Hrs.		9 Birtho	lace (State or Foreign
	Director		579-05-5492	<b>½</b> □M 2□F	90	Yrs.	Months Day	s Hours Min.	(Month, Day, Dec. 25,		eece
	ъ		Usual Residence of Decedent						1000. 23,	1510	eece
	ylan how at		10a. State 10b. County		10c. (	City, Town or Lo	ocation			1	0d. Inside City Limits
	Ma-f s ified	Ş	Maryland M	ontgomery	,	Silv	er Sprin	na			1 ☐ Yes 2 ☑ No
	h the	Directo	10e. Street and Number				10f. Zip Code	- 10	10	g. Citizen of What Cour	ntry?
	h wii		3330 N. Leisu	re World	Blvd.,	#214		20906		USA	
	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin? (S ıban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
9	after or He		1 ☐ Never Married 2 ☐ Marr		2 ☐ No		1 ☐ Yes 2 ☐ N		o riican, eic.)	Black, White,	
5-0036	ral",	l by	3.☐.Widowed 4 ☐ Divorced	Year or	Dates: WW	11	TO THE ZENT	в эреспу.		Specify: Wh	ite
2	72 h natu dical	Completed	15. Deceden (Specify only higher	's Education	()		dent's Usual Occ	upation e during most of wor	kina 1	6b. Kind of Business/In	dustry
7	within iene. than "	햩	Elementary/Secondary (0-12)	<del></del>	(1-4or 5+)	life.	DO NOT use retii	red)	9		
7	ygien /gien er th	Ö	12			Wa	tchmaker	•		Watchmakin	g
land	be filed within 72 ho tral Hygiene. d other than "natul event, the Medical	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle, M	aiden Surname)	
<u>a</u>	should be nd Menta marked martic ev	၉	Gus D. Cokas					Hel	en Panopo	ulos	
Mar	and and is ma	11	19a. Informant's Name/Relations			1				City or Town, State, Zip	Code)
	and 2 salth 27 er tra	9	Helene Catsour	as/Niece		46	09 Bel F	re Raod,	Rockville	MD 20853	
baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.	e 1	20a. Method of Disposition	0 □Demousl from			osition (Name of matory or other p	lace)		0c. Location - City or To	own, State
Ĕ	Pag nert: H int: H		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			te of H	eaven Ce	metery 2	ly 25, 007 Si	lver Sprin	n Maruland
<u>=</u>	permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee		ŕ	Name and Add			Home Inc.	girialylana
מ	o a E c	6 1	linghe	w J.C	ole						g, MD 20901
			23a. Part1. Enter the disease, or	complications that	caused the de						Approximate Interval Between
	Physician	10	shock, or heart failure. List Immediate Cause (Final	offly one cause of	each line.	-x-0 d	en ex	In Post	8		Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or 4s a cons	equence of):	ELLEY	free cert	ζ	disease	
	Examiner			Chi	DIAR	nReite	aptillo	Dully	shorty 1	dispose	
Į.	= 4 =	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a cons	equeno of):		June	J	00000	
	uted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	1 Re	mal	tail	elle				
,	n and	Exa	resulting in death) Last	Due to	o (or as a conse	equince of):					
20	icate be executed physician and the burial-fransit	dical									
Q											
ŏ	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>yes</u> , o	utcome pf preg	inancy				23d. Date of delive	erv
ď	atte I for	cial	in the past 12 months?		birth 2 Fe		⊒Ectopic pregnar ⊒Other (spec <i>ify</i> )	icy		Month	Day Year
j.	the c y the	ysi	9 Unknown	9□Unk	nown						
7	requires that the een signed by th nould be detache		Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cause g	given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
ds	sign d be	d by							1 □ Yes	s 2 No 3 Prob	ably 4 Unknown
Š	/ req	ompleted									
(D)	2 33 2	Idu.							24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
<u></u>	cate ha	S								ed? death?	2 No
VITA	ding Physician: n. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:					th (Check only one	)	
_	bis I	은	1 Yes 2 No	16		☐ ER/Outpatie	" 3 DOA			nce 6 □Other (Specif	y)
_	ding F	ü	27. Manner of Death 1 Dendin 5 ☐ Pendin	(0.4	e of Injury onth, Day Year)	28b. Time o	W		28d. Describe hov	v injury occurred	
<u>0</u>	eath.	Sati	2 Accident investig 3 Suicide 6 Could i	ation				☐Yes 2☐No			
JIVISION	or At ter d irect	Certification:	4 Homicide determ	ined   Zoe. Flac	ce of injury - At ding, etc. <i>(Sp</i> e	home, farm, st c <i>ify)</i>	reet, factory, offic	е	28f. Location (Stre City or Town,	eet and Number or Rura State)	i Route Number,
2	ital c irs af ral D			10				- 5			
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	ical	(Check only 2 Medical	Examiner: On the	basis of exami					use(s) and manner as s te and place, and due to	
	the l	Medical	one)	and ma	nner stated.						
	70 Viti	2	29b. Signature and title of certifie	1 11	1012.1	20, CK	Zac. Lice	nse number	1/1	d. Date signed (Month,	∪ay, Year) "
			1/14/4	ec ous	Spare	en st	100	10374	14	H/22/04	
1	8+1		30. Name and address of person	who completed car	use of death (It	em 23a) (Type	Print	a PH. ID	i- 12-	DO A	10 20000
			Dr. KINKH	MAIN)	10	10101	Trine	x pourer	DAL G	versey 10	1 10 606
	Sta	te	31. Date filed (Month, Day, Year)	2007 32	egistrar's Sig	nature	meets )	/		0	

State of Maryland / Department of Health and Mental Hygie

J. No.		-	100	
ene.	-			

			1 - State Registrar		Cer	tificate	e of L	Death			Reg. I	No.	
Г		-	Decedent's Name (First, Middle, Last)							2. Date of D	eath		3. Time of Death
	Physici /Medic		Wilhelmina		Ca	rr				Month <b>July</b>		2007	6:15 A M
	Examir		4a. Facility Name (If not institution, give street and nun	nber)		4b. City,	Town, or	Location				4c. County of Death	1 0.13 11
			Magnolia Center			Lan	ham				P	rince Geo	rge's
to.	Funeral			7. Age (In yrs. la	* * *	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth		place (State or Foreign ntry)
	Director	Į.	578-34-4515 1□M 2\□F	79	Yrs.	WIGHTIS	Dayo	riodio		4-1-1		Mary	
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10a City	. Town or Lo	antion							
	anyla shov d at	<u>_</u>											10d. Inside City Limits 1
	Ba-f	35		пуас	tsvill								
	ith th	Director	10e. Street and Number			10f. Zip	Code				10g. (	Citizen of What Cou	ntry?
	ath v s 23a nust	Funeral	4804 Stockton Lane			207						ited Stat	
	er de item:	E S	Armed For		5.   13. V	Vas Deced f Yes, spec	lent of Hi rify Cuba	ispanic Ori ın, Mexicai	igin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	lo-	14. Race - Ameri Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or Da	9	1	□Yes 2	2¥ No	Specify:				Specify: Whi	te
3	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	a pe	15. Decedent's Education	165.	16a. Deced	ent's Heus	d Occurs	ation			16h	Kind of Business/Ir	
5	in 72 1 "na ledic	Completed	(Specify only highest grade completed)		(Give	kind of wor OO NOT us	k done c	during mos	t of workir	ng	100.	Kind of Business/ii	luustry
2	withi iene. thar	Ë	Elementary/Secondary (0-12) College (1-	4or 5+)	Manag			,			1	Private	
0	filed Hyg sther	Ö	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middl	e, Maid	en Surname)	
au	ld be ental ked c	To Be	Charles E. Jones					Wi1h	elmi	na Gri	ehe	1	
Maryland 21215-0036	shoul nd M mar	F	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address	(Street a					y or Town, State, Zi	o Code)
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Ethel Jones ( sister )		7611							20783	,
ล์	s 1 al f Hea item othe	-	20a. Method of Disposition	20b. Pla	ace of Dispos metery, cren	sition (Nam	ne of	-		ate		Location - City or T	own, State
Baltimore,	Page: ent o nt: If		1  Burial 2  Cremation 3  Removal from S 4  Donation 5  Other (Specify)	naie	t Linc			1	7/2	7/2007	D.	entwood, l	MT)
	nit. F artm ortar Injur		21. Signature of Funeral Septite Licensee	101	22	. Name and	d Addres	s of Facili	tyFort	Linco	1n	Funeral H	ome
ñ	Dep Imp any onc		I for the			401 B						twood, MD	
	2/		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death.									Approximate
	Dhysisian	ij. J											Interval Between Onset and Death
	Physician /Medical		resulting in death)	Cell C		ma to	ь те:	I C KI	aney				2 months
	Examiner			or as a consequ	erice or).								
11.02		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a conseque	ence of):							-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury										
,	exec n and ial-tra	Exa		or as a conseque	ence of):							-	
68/60,	e be /sicia e bur		L <sub>d</sub>										
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	/Medical											
ŏ	h cer endin use		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, out	ome pf pregnar		F-4						23d. Date of deliv	ery
20	death e atten	icia	1 Ves 2 ANo 4 Pregna	rth 2□Fetal ant at time of de		Ectopic pre Other (spe						Month	Day Year
r Ö	it the by th	Physician	9 ☐ Unknown 9 ☐ Unkno	wn									
S,	requires that the een signed by tha	by P	Part II. Other significant conditions contributing to de	ath but not resul	ting in the un	derlying ca	ause give	en in Part I		23e. Did	tobacc	o use contribute to t	he cause of death?
ğ	equire en sig	pa								1 🗆	Yes	No 3□ Pro	bably 4 □Unknown
ecord	at to or	Completed								24a. Wa		24b. Were auto	opsy findings available ompletion of cause of
r	The lav	lmo								per	opsy formed?	/   death?	
VItal		Ф	25. Was case referred to medical					26. Place	of Death	1 Yes (Check only		No 1 ☐ Yes	2 L NO
	Physician: this certific	0 8	examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Ir	patient 2 E	R/Outpatient	3 □ DO.	A Othe					6 □Other (Speci	f <sub>V</sub> )
0	ding Phys h. After this funeral di	Ë	27. Manner of Death 28a. Date of	f Injury n, Day Year)	28b. Time of Injury	28	Bc. Injury Work					jury occurred	
SION	tending Fleath. tor: After the funera	atio	1 X Natural 5 □ Pending (Month 2 □ Accident investigation	i, Day Tear)	Irijury	М		Yes 2□	No				
<u>                                      </u>	Atte	iţic	3 Suicide 6 Could not be 4 Homicide determined 28e. Place buildin	of injury - At hor g, etc. (Specify)	ne, farm, stre	et, factory,	, office		2	8f. Location	(Street	and Number or Run	al Route Number,
<u>&gt;</u>	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	- Dundi	g, etc. ( <i>opeony)</i>						City or To	JWII, SIE	ile)	
	ospit hour unera ly fille		29a. Certifier (Check only 2 Medical Examiner: On the ba	best of my know	ledge, death	occurred a	at the tin	ne, date ar	nd place, a	ınd due to th	e cause	(s) and manner as	stated.
	he H in 24 he Fi plete	Medical	one) and mann	e stated.	on and/or inv	esugation,	in my o	pinion, dea	atri occurre	ed at the time	e, date a	and place, and due i	o the cause(s)
	Vith To t	Ž	29b. Signature and title of certifier	) .	10 5	29c.	. License	number			29d. [	Date signed (Month,	Day, Year)
)			Mullim )	assi	IN H	4)	D 16	5897			7	7-24-2007	
	(10)		30. Name and address of person who completed cause	of death (Item	23a) (Type, F	rint)							
	(10)		William D. Rosson, MD	5701 8		e. N	lew (	Carro	11tor	ı, MD	2078	34	
	Sta		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signat	ire								
	Registr	ar	JUL 2 6 2007 Same	D. 190	ur								
ВΗ	MH 17 Rev 1/20	001											

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryla  State Registrar		Certificate of L		Reg.	10 10 100	ostana
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death     Mortin	Day Year	3. Time of Death
	/Medic	al	GEORGE KASEY COLE JR.		4b. City, Town, or	Location of Death	July 2	4c. County of Deat	0247 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Prince George's Hospit	al	chev			Prince	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yr.	s. last birtho	Months Days	If Under £4 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
b	Director		577-06-8091 40 Usual Residence of Decedent	Yr	S.		Dec. 22,	1966 D.C	
	land ow			City, Town o	or Location				10d. Inside City Limits
	a-f sh	ctor	D.C.	Vashin	gton				1 □Yes 2X No
	or 28	Dire	10e. Street and Number		10f. Zip Code	_	10g	. Citizen of What Co	untry?
	s 23a nust k	Funeral Director	3238 Walnut St N.E.  11 Marital Status 12. Was Decedent Ever in	II S	2001		ocify Ves or No.	USA 14. Race - Ame	rican Indian.
	fter de r item iner r	Fun	Armed Forces?  1 ⊠Never Married 2 □ Married 1 □ Yes 2 ☒ No	0.0.	13. Was Decedent of His If Yes, specify Cuba		Rican, etc.)	Black, Whit	
2-0036	be filed within 72 hours after death with the Maryland ttal Hygiene.  dother than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 🔼 No	Specify:		Specify:	Black
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occupa Give kind of work done d ife. DO NOT use retired,	ation furing most of work I	ing	b. Kind of Business/	Industry
12	withir iene. than the Me	dwa	Elementary/Secondary (0-12) College (1-4or 5+) 12th	1	Body Shop			Self Emp	loyed
5		Be C	17. Father's Name (First, Middle, Last)				(First, Middle, Ma	iden Surname)	
<u>lar</u>	2 should be i and Mental is marked o raumatic eve	To E	George K. Cole Sr.			Norma	Davis		
Maryland	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type. Print)		Mailing Address <i>(Street a</i> 38 Walnut St			City or Town, State, $^{2}$	
	1 and Health em 27 ther tr		Nora L. Murphy/Sister  20a. Method of Disposition 20b		Disposition (Name of crematory or other place			c. Location - City or	
Baltimore,	Pages nent of l int; If Its iry or o				ncoln Cemet		-2007	Brentwood	, MD.
<u>≡</u>	permit. Pag Department Important; Ii any injury o		21. Signature of Funeral Service Licensee		22 Name and Addres Marshall s			2.	
8	e a E e		> gr. P. Marshall		4217 9th_9	St. N.W.	Washingt	on, DC 20	
			23a. Pand. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Arterios  Due to (or as a cons	de	votic Hy	perta	ive To	an Dis	care
	Examiner			equence of	,.				
Е,	DEADTHE !	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equance of	)·				
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events c	equence of	١٠				
68760,	ficate be executed physician and is the burial-transit		bue to (or as a cons	equesioe of	,-				
687		edical	d				-		
Box		M/ue	IF FEMALE: 23c. If yes, outcome pf precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the precapity of the pr		3 □Ectopic pregnancy			23d. Date of de	
	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician//	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		5 ☐ Other (specify)			Month	Day Year
P.0	w requires that the deben signed by the should be detached	Phy	Part II. Other significant conditions contributing to death but not r	esulting in t	he underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	o the cause of death?
ds,	uires signe Id be	d by					1 ☐ Yes	2 No 3 P	robably 4. Durknown
Records,	aw rec s beer 2 shou	Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
Ä		om)					autopsy performe 1□ Yes 2	ed? death?	
Vita	ysician: The iis certificate hadirector, page	Bec	25. Was case referred to medical examine:		Louis		h (Check only one)		
<u>_</u>	Physi this c	မ	1 lospital: 1 lospital: 2 lospital: 1 lospital: 2 lospital: 1 lospital: 2 lospital: 2 lospital: 1 lospital: 2 lospital: 2 lospital: 1 lospital: 2 lospital: 1 lospital: 2 lospital: 2 lospital: 1 lospital: 1 lospital: 2 lospital: 1 lospital: 2 lospital: 2 lospital: 1 lospital: 2 lospital: 1 lospital: 1 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 1 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 lospital: 2 los	ER/Outp	ne of 28c Injur	4 □ Nursing Ho	me 5 Residen	ce 6 Other (Spe	ecify)
O	Attending Physician: r death. ector: After this certification the funeral director.	tion	1. Natural 5 ☐ Pending (Month, Day Year, 2 ☐ Accident investigation		ury Worf	رُ? Yes 2 ☐ No	200. 20001120 11011	injury cocurrou	
Division or	Atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - A' building, etc. (Spe	t home, farr c <i>ify</i> )	n, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	ital or irs afte ral Dir led in	Cert							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my leading one)  One only one of the certifying Physician: To the best of my lead of the certifying Physician: To the best of my lead of the certifying Physician: To the best of my lead of the certifying Physician: To the best of my lead of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the certification of the cert	nowledge, ination and	death occurred at the tir or investigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier		29c. License	e number	290	d. Date signed (Mon	th, Day, Year)
	F > F 0		Jarada Lelet	00	Ho	05597	つ」」	ul 25)	2007
0			30. Name and address of person who completed cause of death (I	tem 23a) (T	1 1	) .	1	1	0.
			31. Date filed (Month, Day, Year) 32. Registrar's Signature 1	gnature 5	pital L	m, ve	rown	y 140	year
	Sta Regist		JUL 2 6 2007 Seven D.	ford					

Physic /Medi Exami

**Funeral** Director

	Please	Type or Print i				•	•	
	For State Registrar	State of Mary		irtment of H <i>tificate of L</i>		, ,	iene eg. No	25400
ian cal	Decedent's Name (First, Middle, L. HATTIE	ast) CHAPLIN				2. Date of Deat Month JULY	h Day Year 22 2007	3. Time of Death 2034 M
ner	4a. Facility Name (If not institution, gi Prince Georges H  5. Social Security Number 6.	ospital	yrs. last birthday)	4b. City, Town, or  Chever  If Under 1 Year	_		4c. County of De. Prince G	eorges
8		1 M 2 X F	81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 2,	Year	rthplace (State or Foreign Country) uth Carolina
ctor	10a. State 10b. County DC	100	c. City, Town or Loc Washin					10d. Inside City Limits 1 ☐ Yes <b>※</b> ☐ No
ral Dire	10e. Street and Number 5133 33rd Stree			10f. Zip Code 20008		10	og. Citizen of What C	Country?
Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	li li	Vas Decedent of Hi i Yes, specify Cuba □ Yes 2🗓 No	spanic Origin? (Spe n, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
complete	15. Decedent's E (Specify only highest gi	Education rade completed)  College (1-4or 5+) 5+	(Give H	ent's Usual Occupa kind of work done d OO NOT use retired, 1 Teacher	luring most of workir )	ng	16b. Kind of Busines:  DC Publi	s/Industry
To Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name Lila Dar	niels		
	19a. Informant's Name/Relationship Russell Chaplin/	Son	White	e Plains,	Md. 2069		City or Town, State,	Zip Code)
	20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	_nemovar nom State	Ob. Place of Dispos cemetery, crem Metropoli		etory 7-20		20c. Location - City o	
	21. Signature of Funeral Service Lice	arshall	4	217 9th S		Washing	ton, D.C.	20011
	23a. Part1. Ther the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the yone cause oppeach line.	death. Do not ente	er the mode of dying	such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
J.		b. Due to (or as a cor	uner	Dise	ase			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cor						
ledical		d						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year
4	Part II Other significant conditions	contributing to death but not	t resulting in the un	derlying cause give	n in Part i	23e Did toh	acco use contribute	to the cause of death?

1 🗌 Yes

27. Manner of Death 1. Natural

2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

29a, Certifier

25. Was case referred to medical examiner?

20 No

5 ☐ Pending investigation

6 ☐ Could not be

determined

Completed by

Be

Certification: To

Medical

2 R/Outpatient

28b. Time of

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 | Inpatient

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24a. Was an autopsy perform 1☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred

Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many er stated. 29d. Date signed (Month, Day, Year) 7-23-07 29c. License number 29b. Signature and title of certifier D58957

eted cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day, Year)

JUL 2 6 2007 State Registrar

32. Registrar's Signatu

10

			1 - For State Registrar	State of	Marylar		artmen rtificat				ental Hy	gien Reg. No		25419
1	100 B		Decedent's Name (First, Middle, La	st)							2. Date of De	ath		3. Time of Death
	Physic /Medi		John Philip Dy	son, Sr.							July 29	9 Da		4:30A M
4	Examir		4a. Facility Name (If not institution, giv 37581 New Mark		oer)		* * *		Location	of Death		40	County of Dea	th
100	Funeral Director		212-34-1383	Sex XIM 2□F	Age (In yrs. 78	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da lovembe	y, Year,	)   Co	thplace (State or Foreign buntry) Maryland
	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	Maryland St. Ma	ry's		Charlo	tte H	la11						1 ☐ Yes 2 X No
	h with the	ai Dire	10e. Street and Number 37581 New Market	Rd.			10f. Zip 20	Code 622					itizen of What Co	ountry?
036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, I'm Medical Expriner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Forc 1X Yes 2 If Yes, Give Year or Date	□Nº 19		Was Deced f Yes, spec	ify Cuba	spanic Or n, Mexica Specify	n, Puerto P	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify: W	
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	16a, Deced (Give life.	lent's Usua kind of wor DO NOT us	rk done c	<i>lurina</i> mo:	st of workir	ng	16b. h	Kind of Business	Industry
7	filed wi Hygien Sthar th	Con	12			Manag	er						nvenienc	e Store
and	ould be fil Mental H arked oti atic even	To Be	17. Father's Name (First, Middle, Last) Elbert V. Dyson								(First, Middle, Herbe		n Sumame)	
Maryland	d 2 should be filed withir th and Mental Hygiene. 7 is marked othar than traumatic event, I'm Ny	F	19a. Informant's Name/Relationship ( John P. Dyson, Jr	** *					ind Numb	er or Rura		r, City	or Town, State, 2	Zip Code)
Baltimore,	Pages 1 and 2 ment of Health ant: If Item 27 art or other tra		20a. Method of Disposition  1  Burial 2  Cremation 3  4  One of Donation 5  Other (Specification)	Removal from St	20b. I	Place of Dispo cemetery, crem en of	sition (Nan	ne of	T	D	ate t 1,200	20c. L	ocation - City or Helen,	
Balti	permit, Pagi Deportment Important: ti any njury o		21. Signature of Funeral Service Licer											., P.A., 1, MD 20622
4	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cau one cause on each	n line.									Approximate Interval Between Onset and Death
τ 1.0x	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):	CINE	D.	I.MO	NAR	-Y D19	cas	F.	YEARS
8760,	cate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec	quence of):	7100	70		,		<i>7</i> 170		
687		edicai		d										
P.O. Box	at the death certifi by the attending prached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2∏ Feta tattime of c	al death 3	Ectopic pre Other (spe						23d. Date of del Month	ivery Day Year
	The faw requires that the tee bas been signed by the base been signed by the bage 2 should be detache	b	Part II. Other significant conditions of DIABETS	ontributing to deat	th but not res	sulting in the ur	nderlying ca	iuse give	n in Part I	l.		_		o the cause of death?
Division of Vital Records,	: The law rec cate has beer , page 2 shou	Completed									24a. Was autop	sy /	24b. Were au prior to death?	itopsy findings available completion of cause of
ī	icien: Th certificate ector, pag	e Co	25. Was case referred to medical						00 Bt		1 ☐ Yes	2 No		20 No
5	ysicie is cert direct	o B	examiner?	Hospital:	atient 2	ER/Outpatien	3 DO	A Othe	F		(Check only or		6 □Other (Spec	cutul.
<u>0</u>	ng Ph fter thi neral	n: T	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of		28b. Time of		Bc. Injury Work			8d. Describe h			cuyy
S	or Attendii Iter death. Irector: A n by the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2□					
<u>&gt;</u>	tal cristal	Certification:	4 Homicide determined	building	, etc. (Specif						City or Tow	n, State	э)	ıral Route Number,
	To the Hospi within 24 hour To the Funer completely fill	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manner	s or examina	owledge, death ation and/or inv	occurred a estigation,	at the tim in my op	e, date ar inion, dea	nd place, an ath occurre	nd due to the o	ause(s date and	) and manner as d place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and Mile of certifier				29c.	License	number		2	29d. Da	te signed (Monti	h, Day, Year)
			> Roland		K	UD		DV	090			7	7-30-0	07
			30. Name and address of person who o	completed cause of	of death (Item	n 23a) (Туре, I	Print) 4035	Thre	e No	tch R	d., Hol		rood, MD	
5	Sta Registr		31. Date filed (Month, Day, Year) <b>AUG</b> 0 1 2007	32. Reg	istrar's Signa	ature	6							

	State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department / Department State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Depar	artment of Health and M rtificate of Death	Reg. No.	007 25W
Physician	Decedent's Name (First, Middle, Last)     RICHARD WARREN DAVIS		2. Date of Death Month Day JULY 28	3. Time of Death 2007 5:25 A
/Medical Examiner uneral irector	4a. Facility Name (If not institution, give street and number)  CHARLOTTE HALL VETERANS HOME  5. Social Security Number  285-26-2850  6. Sex  ▼MM 2□ F  7. Age (In yrs. last birthday)  Yrs.	4b. City, Town, or Location of Death  CHARLOTTE HALL  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	4c. Cou	MARY S  Significantly  Significant State of Foreign Country)  OHIO
or 28a-f show be notified at Director	Usual Residence of Decedent		10g. Citizen o	10d. Inside City Limits 1 □ Yes 2 No of What Country?
or items 23a miner must y Funeral	1 ☐ Never Married 2 ☐ Married 1 1 1 No	20622 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		S. A. Race - American Indian, Black, White, etc. WHITE
than "natu he Medical	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Dece (Give life.)  College (1-4or 5+)  INVES		REAL	f Business/Industry  ESTATE
is marked other aumatic event, t	17. Father's Name ( <i>First, Middle, Last</i> )  GEORGE WARREN DAVIS  19a. Informant's Name/Relationship ( <i>Type. Print</i> )  19b. Mailli	LEONA C		
tant: If	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposemetery, cre  BRINSFIEL	D-ECHOLS CR. 2007	Date 20c. Location CHARLO	on - City or Town, State
any in		2. Name and Address of Facility BR3 0195 THREE NOTCH Is ter the mode of dying, such as cardiac	RD. CHARLOTTE	
physician and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the burial-transit and street leading to the b	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Anewia.	cardiomyonany Avten ostructive of Chronic	Disease Pulmona c diseas	y Disease
d by the attending etached for use a Physician/Me		□Ectopic pregnancy □ Other (specify)	23d.	Date of delivery Month Day Year
en signed to	Part II. Other significant conditions contributing to death but not resulting In the University Preval Vascular	underlying cause given in Part I.  Discuse	23e. Did tobacco use o	contribute to the cause of death?
ficate has been s r, page 2 should Completed	Chronic Kidney Dise	ase	autopsy performed? 1☐ Yes No	4b. Were autopsy findings availabl prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
To the Fundal Breaton: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	25. Was case referred to medical examiner?  1	of 28c. Injury at Work?  M 1 Yes 2 No	th (Check only one)  ome 5 Residence 6 28d. Describe how injury oc  28f. Location (Street and Nic City or Town, State)	
or the Funeral Completely filled i	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal manner: On the basis of examination and/or in and manner stated.			
Tota	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type  110 Hospital Road Suite	29c. License number D 45092		gned (Month, Day, Year)
State	31. Date filed (Month, Day, Year)  32. Registrar's Signature	e 205 Princ	efredvi	ck, MD 206

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	1	For State Registrar	te of Marylar		rtment of H <i>tificate of I</i>			iene eg. No. 🗥 🦷	1 ***	951.11	
Physician		1. Decedent's Name (First, Middle, Last)  Helen A.	Downing	Y			2. Date of Death Month July	Day	Year <b>007</b>	3. Time of Death 6:10 PM	
/Medical Examiner		la. Facility Name (If not institution, give street a  Wicomico Nursing Hom	nd number)	,	4b. City, Town, or Salisbu	Location of Death	July	4c. County	y of Death	10:10 PM	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthp Cour	Birthplace (State or Foreign Country) ermont	
Maryland -f show ied at		Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico		ty, Town or Loc						0d. Inside City Limits	
ifter death with the Mar r items 23a or 28a-f sl niner must be notified Firneral Director	ם חובר	10e. Street and Number 422 Elberta Ave.			10f. Zip Code 2180	01	10	og. Citizen of	What Cou	ntry?	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Rem 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Re Completed by Financial Director	Dy ruiler	1 Never Married 2 Married 1 If Y	s Decedent Ever in Uned Forces? ]Yes 2 ☑ No es, Give ar or Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:		ce - Americ ack, White, fy:			
d within 72 ho giene. r than "natur the Medical"										dustry	
Mental Hygarked otheratic event,											
and 2 sho ealth and f n 27 Is ma er traums		n, State, Zip 2180	1								
permit. Pages 1 Department of He Important: If Iten any injury or oth		20a. Method of Disposition  1			sition (Name of natory or other place Cemetery	7/2°	7/07	20c. Location Salis	- City or To sbury	,	
permit. Departimporta	(	Tonic Home	DON CFSA						nal A D 218	ssociatio 04	
Physician /Medical Examiner	9	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause immediate Cause (Final disease or condition resulting in death)	on each line.	NG 1	ARTIC		ECT 600	,		Approximate Interval Between Onset and Death	
100	ĭ	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or as a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecut	,							
The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	ysiciali/lweu	in the past 12 months?	es, outcome pf pregr Live birth 2 □ Fet □ Pregnant at time of □ Unknown	al death 3	Ectopic pregnancy	1			ate of deliv	ery Day Year	
w requires that sheen signed by should be detailed by the should be detailed by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by	2	Part II. Other significant conditions contribution HYPERTENSION	ng to death but not re	sulting in the ur	nderlying cause giv	en in Part I.				he cause of death?	
The law recate has bee page 2 shou	performed? death?									opsy findings availal impletion of cause of	
ysician is certifi director	מ	25. Was case referred to medical examiner?  1  Yes 2 No Hospita	1   Inpatient 2	· · · · · · · · · · · · · · · · · · ·		er: Nursing H	th <i>(Check only on</i> ome 5 ☐ Reside	ence 6 □Ot		fy)	
Attending r death. ector: After by the fune	eruncation:	Natural 5 ☐ Pending investigation	Date of Injury (Month, Day Year)  Place of injury - At houlding, etc. (Spec	28b. Time of Injury	M 1 □	y at k? Yes 2 ☐ No	28d. Describe ho	reet and Num		al Route Number,	
To the Hospital or within 24 hours after within 24 hours after completely filled in Modical Control	edical	29a. Certifier Check only one) 2 Medical Examiner: O	To the best of my kn n the basis of examin nd manner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	me, date and place	e, and due to the corred at the time, d	ause(s) and n late and place	manner as	stated. to the cause(s)	
To the within to the comp	Me	29b. Signature and title of certifier	NI,	MD	29c. Licens	e number	5/5	9d. Date sign	25/0	Day, Year)	
100		30. Name and address of person who complete Maesha Thimmarayapp				Dr Sali	sbury MD	21804	/	*	
State	е	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	9						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 July **Physician** 23 5:45 AM James Demonia Willie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 1319 Crisfield Dr Oxon Hill | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr 23 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Year 938 Months 1**₽** M 2□ F 247-62-1324 69 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10h County or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Prince George's Oxon Hill MD Directo 10g, Citizen of What Country? 10f Zip Code 10e. Street and Number 1319 Crisfield Dr 20745 U.S.A. 236 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Items Black, White, etc. filad within 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 No Black Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced "naturel" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation treumatic event, the Medicul 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 9th permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treument. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruther Mae Kennedy James Demonia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1319 Crisfield Dr Oxon Hill MD 20745 Renell Demonia - Wife Date 2007 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery July 28 Washington DC `4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility D L McLaughlin Funeral Home 21. Signature of Funeral Service Licensee 2019 MLK JR Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death year 9mo Immediate Cause (Final Metastano Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requiras that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. Physician/Medlcal the t use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes 2 XNo Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA <sup>o</sup> 1 ☐ Yes 2 💢 No this 28c. Injury at Work? 28d escribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide determined 4 | Homicide 24 hours a Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of rson 1160 VAMUM St. N.E. DC 20017 WAShing HORTON MI 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 5 2007 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 July 28, **Physician** Wanda Ivette Davila 1:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 650 Jennifer Lane Aberdeen Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/31/1963 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F Director 218-92-4811 43 Maryland Usual Residence of Decedent with the Maryland wode 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "naturel", or Items 23a or 28a-f eho treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 21 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 650 Jennifer Ln. 21001 Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 √Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Puerto Rican Specifican Rican þ 3 ☐ Widowed 4 ➡ Divorced Year or Dates: U.S. Army Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Hotel permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Importent: If Item 27 Is marked other any Injury or other treumatic auch 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesus Davila Cristina Reves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristina Davila (Mother) 650 Jennifer Ln. Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🎇 Removal from State Cementerio Nuevo 8/6/07 \* 4 ☐ Donation 5 ☐ Other (Specify) San Lorenzo, P.R. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death metasi Immediate Cause (Final ah Cance **Physician** (cona months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Pe 1 res 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an has autopsy performed? certificate 1 🗌 Yes 2 🗆 No Yes 24 Division of Vital : After this certifice e funeral director, s Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1-Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date/signed/(Month, Day, Year) 29b. Signature and title of certifier D54841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashkan Bahrani 602 S. Atwood Rd., Bel Air, Md., 21014 31. Pate filed (Month, Day, Year) 32. Aegistrar's Signature State Registra

			For State Registrar	olate of Marylan		rtificate of		vioritai i iy	Reg. No.	2117	951.1	
	Dhysisi		1. Decedent's Name (First, Middle, La.	st)				2. Date of De Month	ath Day	Year	3. Time of Death	
	Physici /Medic		PAUL	ROBERT	FOUT			AUGUST	-	2007	8:40P M	
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death	n	4c. (	County of Death	1	
			FREDERICK MEMORI			FREDER	ICK If Under 24 Hrs.	To But (B)		REDERIC		
ű	Funeral Director		213 20 3007	ex 7. Age ( <i>In yrs.</i> 1	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Mar 14		Cou	place (State or Foreign intry) yland	
	Maryland f show ied at	or	Usual Residence of Decedent  10a. State  Maryland  Trederi		rederi		-				10d. Inside City Limits 1 Yes 2 No	
	with the I sa or 28a- t be notif	Director	10e. Street and Number 200 East 16th Sti	reet		10f. Zip Code	701			zen of What Cou	untry?	
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show ilcal Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1X Yes 2 No 195 If Yes, Give Year or Dates:	1-	Usa Decedent of Half Yes, specify Cub		pecify Yes or No to Rican, etc.)		4. Race - Ameri Black, White Specify:		
21215-0036	within 72 h iene. than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor d)	rking		nd of Business/li	•	
1d 21	should be filed nd Mental Hyg marked other matic event, I	Be Con	12 17. Father's Name ( <i>First, Middle, Last,</i>	)	Park	Ranger	18. Mother's Nan			Mat'l Park Service aiden Surname)		
Maryland		To	Paul F Fout  19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Street	Mebal M		er. City or	Town, State, Zi	ip Code)	
	1 and 2 s Health ar em 27 is ther trau		Linda Anderson, I	11e, OF								
Baltimore,	. Pages tment of I tant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Mt	emetery, cre Olive	osition (Name of matory or other place t Cemeter	y Aug 4		Fred	lerick,	Maryland	
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Liver	M00706		².Reeneyda 06 East (					and 21701	
	Dhysisian		shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not en	ter the mode of dyin	ng, such as cardiad	or respiratory a	rrest,	-	Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		disease or condition resulting in death)	a	uence of):	jocariou	ac sh	Journ	767-	- 1		
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b to (or as a consequ	uence of):							
30,	rtificate be executed ng physician and as the burial-transit	Examine	that initiated events resulting in death) Last	CDue to (or as a consequ	uence of):							
68760,	tificate b g physic as the bu	Medical		<b>⊾</b> d								
P.O. Box	ath cer	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of de 9□Unknown	Ideath 3	⊒Ectopic pregnanc ⊒ Other <i>(sp</i> ec <i>ify)</i> _	у		2	23d. Date of delivery Month Day Year		
	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions of \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 and \$100 an		ulting in the u	nderlying cause giv	ven in Part I.		tobacco us Yes 2□		the cause of death?	
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<u>=</u>	ate Pag	Con	//					perfo 1⊟ Yes	ormed? 2 □ No	death? 1 □ Yes	2 No	
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or	is dir	2	1 Yes 2 No	Hospital: 1 Inpatient 2 2		nt 3 DOA Oth	4 LI Nursing F	lome 5 ☐ Resi			ify)	
nc	ding l	ion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time o Injury	Woi	ryaτ rk?  Yes 2∐No	28d. Describe	now injury	/ occurred		
Division or Vital Records,	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined				100 2 110	28f. Location ( City or To			ral Route Number,	
	ne Hospitz 124 hours ne Funera aletely filled	Medical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.								
	To th withir To th comp	Me	29b. Signature and title of certifier	e mD.		29c. Licens			29d. Date	e signed (Month	, Day, Year)	
			30. Name and address of person who		23a) /Tuna		4636		Augu	ıst 3, 2	2007	
	4		Sved Hague, M.D.	700 Montclair	e Ave	nue. Fred	derick, M	laryland	2170	)1		
	。 Sta Registr		31. Date filed (Month, Day, Year)  AIIG 0 8 200	32. Registrar's Signa	ture	W.	-					
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DHMH 17 Rev 1/2001

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RICHARD FISHMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#7. PerFHPCC7-25-07cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .. 9, 2007 JULY Month Physician JOSEPHINE **GRAY**  $A^{\mathsf{M}}$ 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CLINTON REHABILITATION CENTER CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year)
FFB. 22,1921 If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2▼F 86 577-20-3993 487 Director NORTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 No Directo D.C. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2304 RAYNOLDS PL., S.E. 20020 UNITED STATES tems 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK ģ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) DOMESTIC DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental I em 27 is marked of PAUL GRAY CATHERINE GRAY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNNIE BELSER/SON 12116 BIRCHVIEW DR., CLINTON, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLENWOOD CEMETERY 7/19/07 WASHINGTON, D.C. 21. Signature f Funeral Service CAPITOL MORTUARY WASHINGTON, D.C. 20002 1425 MARYLAND AVE., N.E. 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Colone Physician 0 /Medical Due to (or as a conservence of) Examiner Sequentially list conditions, and leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft le Funeral Di lletely filled ir 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of de Name and address of Date filed (Month, Day, 32. Registrar's Signature State Registrar

that the death certificate be executed P.O. Box 68760, Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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s 1 and 2 should be fill Health and Mental H tem 27 is marked oth

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Department of Health ar
Important: If item 27 is
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Physician

/Medical Examiner

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funeral

physician

Director

Funeral

Completed by

Be

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division or Vital

certificate GRAY After this e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti RUBY MARIE To the Hospital within 24 hours at To the Funeral D Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

7/29/07

Registrar

State

SHAH ASSOC HOLLYWOOD, MD

20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

DR DAVID FEDERLE

31. Date filed (Month, Day, Year)

JUL 3 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Dav Year **Physician** 842 PM Meggan 2007 HULLOCK JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Baltimore City Baltimore City The Johns Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) . Age (In yrs. last birthday Date of Birth **Funeral** 1 □ M 2 🕱 F 10/29/1982 221-66-3088 24 Director Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits New Castle New Castle 1 ☐ Yes 2 X No DF: Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 S. Purdue Avenue 19720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) College Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry L. Hurlock III Ellen Maxine Marcus 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Maxine Hall / Mother 17 Oak Avenue, Westville, NJ 08093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Marior Memorial 7/28/07 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkton, MD 4 Donation 5 Dother (Specify) <sup>22</sup> Name and Address of Facility Strano & Feeley Family Funeral Home 635 Churchmans Rd, Newark, DE 19702 21. Signature of Fymeral Service Licenses low 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** one month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tmmunosupression

Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Ung transplant
Due todor as a consequênce of): lung that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1∐ Yes 1 ☐ Yes 2□No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director; 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 inshure, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street Baltimore

DHMH 17 Rev 1/2001

State

Registrar

Sunshine

Dara Neuman -31. Date filed (Month, Day, Year)

26

			1 - For State Registrar	State 0	i waryiand		rtificate o				giene Reg. No.	) H	1	
ľ	Physic		1. Decedent's Name (First, Mid An gela	ddle, Last) Mar	ie		Ha.	1600		Date of Dea Month	ath Day	Ye 20	ar	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institut				4b. City, Towr			ugust		County of D		0311 11
34.			The Johns 5. Social Security Number	Hopkins +	7. Age (In yrs. la	act hirthday)	Balt If Under 1 Ye		Uty er 24 Hrs. 8	. Date of Birtl			District	(0)
b	Funeral Director		219-96-2672 Usual Residence of Decedent	1 □ M 2 1 □ F	38		Months Day		Min.	Month Day	, Year) 19	69 M	Countr lary	Ice (State or Foreign
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980	ges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b	11. Marital Status 1 □ Never Married 2 🛱 M 3 □ Widowed 4 □ Divorc	Armed Fo arried 1 ☐ Yes If Yes Gi	2⊠No e	l II	Vas Decedent of Yes, specify C			fy Yes or No- can, etc.)		4. Race - A Black, W Specify:		tc.
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ıland	uld be fi Mental F rked otl	To Be	17. Father's Name ( <i>First, Midd</i> Joseph Ford H					18. Mot	ther's Name <i>(F</i> Sandr	ra Lee				
, Maryland	and 2 sho salth and h 27 Is ma er trauma		19a. Informant's Name/Relation John Marshall		usband		g Address <i>(Stre</i> Box 92		nber or Rural F laway,			Town, Stat	te, Zip C	Code)
Baltimore,	p.rmit. Pages 1. Department of He Important: If Iten any injury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		State 1		sition (Name of natory or other p e Cemete		August 200	t 6,		ation - City		m, State Maryland
Balt	p.rmit. Pag Department Important: h any injury o		21. Signature of Funeral Servi	ce Licensee	(un)	22	Name and Ad Mattingle P.O. Box	dress of Fac ey-Gard 270	ility iner Fun Leonardt	eral Hono	ne, P. 20650	.A.		
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Division	<u>=</u> 5 ∰ 5	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 200. Place	of injury - At hon ng, etc. (Specify)	ne, farm, stre	et, factory, offic	e	28f	Location (S City or Tow	treet and n, State)	Number or	r Rural I	Route Number,
	the Hospital hin 24 hours a the Funeral mpletely filled	Medical (	29a. Certifier 1 ☑ Certification (Check only one)	ying Physician: To the al Examiner: On the ba and manr	isis of examinati	rledge, death on and/or inv	occurred at the estigation, in m	time, date a y opinion, d	and place, and eath occurred	d due to the o	cause(s) a date and p	and manne place, and	r as stat due to t	ted. he cause(s)
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			For State Registrar	State	of Marylan		artment of H ctificate of I		l Mental Hy	giene Reg. No.	FVI) "	0010
ļ.	Physici	an	1. Decedent's Name (First, Middle,			imodio or i		2. Date of De Month	eath Day	Year	3. Time of Death	
	/Medic	al	John Kauft 4a. Facility Name (If not institution, g				4b. City, Town, or	Location of De	July 3		07 ounty of Death	12.05 A M
\$3.T	Examin	er	10655 Iron Mine		anno ory			tte Hal			harles	
<i>b</i> <sub>7</sub>	Funeral Director		5. Social Security Number 213-38-3310	.Sex 1∐XM 2□F	7. Age (In yrs.	last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n (Month, Da	rth ay, Year) 28 <b>,</b> 1934	Cour	olace (State or Foreign otry) sylvania
	land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e Mary a-f sh lified a	ctor	Maryland Charl	.es		Charlot	te Hall					1 □ Yes 2 No
	vith the	Director	10e. Street and Number				10f. Zip Code				n of What Cour	ntry?
	ns 23s	Funeral	10655 Iron Mine	12. Was De	cedent Ever in U	.S. 13. \	206 Was Decedent of H	ispanic Origin?	(Specify Yes or No	US - 14.	·A . Race - Americ	an Indian,
336	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 ☐ Yes If Yes, G Year or	2 X No		fYes, specify Cuba I∐Yes 2∭XNo	an, Mexican, Pu	èrto Rican, etc.)		Black, White, pecify: Wh	etc. nite
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Baltimore,	permit. Pages. Department of I Important: If its any injury or of		21. Signature of Funeral Service Lie	censee	/	22	. Name and Addres	s of Facility	httingley-	Gardine	r Funera	L Home, P.A.
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	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	cy F.	- in Color				
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<b>1</b>	s that gned b	by Ph	Part II. Other significant condition		death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
ord	w requires that been signed b should be deta	ted t	Diabetes Melli	tus II					115	Yes 2□1	No 3□ Prob	ably 4 □Unknown
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0	nding F th. r: After e funera	tion	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mo	nth, Day Year)	Injury	Wor	k? Yes 2 □ No	EGG. Describe	now injury o	couried	
DIVISION OF	pital or Attend ours after death, leral Director: / filled in by the f	Certification:	3 Suicide 6 Could not determine	200. Flat	e of injury - At ho ding, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and N wn, State)	Number or Rura	il Route Number,
	Hos Fur tely	Medical C	29a. Certifier (Check only one)  1   ☐ Certifying 2  ☐ Medical Ex	aminer: On the	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred at the tirvestigation, in my o	ne, date and pla pinion, death o	ace, and due to the ocurred at the time	e cause(s) ar , date and pl	nd manner as s ace, and due to	tated. o the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. License				signed (Month,	Day, Year)
)				in ks				345		08/	/02/07	
			30. Name and address of person when 29015 Three No.									
	Sta		31. Date filed (Month, 2007 ar)		Registrar's Sig							
	Registr	ar	MARIA O WALL	THE RESERVE								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Nellie Irene Hillman $A^{M}$ 2007 29 Julv 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Williamsport Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 👿 F 236-32-1224 82 **Director** Feb. 26,1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc a or 28a-f show the notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a odleal Examiner must b 13043 Resh Road 21740 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Animal Research Technician</u> Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Frank Allen Thomas <u>Elizabeth</u> <u>Callahan</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda L. Hyman - Daughter 13043 Resh Road Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of F Important: If ite any injury or ot once, 5 Other (Specify) Smithsburg Crematory 7-30-2007 Smithsburg, Maryland 4 Donation 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of June 21 425 S.Conococheague St. Williamsport,MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimers Disease years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner burial-tran and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 2 No 3 Probably 4 Unknown Coronary Artery 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Disease Osteoporosis 1□ Yes 2 🗖 📉 o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Varsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 

J3H-5 State

30. Name and address of person who complete	
Cynthia Kuther-Sands	ND 16505 VIFGIN
31. Date filed (Month, Day, Year)	32. Pegistrar's Signature

JOT 3 0 5001

Kutther-Sands, wo

and manner stated.

Registrar

29a, Certifier

29b. Signature and title of certifier

Cynthia

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Avenue

29d. Date signed (Month, Day, Year)

July 29, 2007

Williamsport, Maryland 21795

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 0034 M nandler 24 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Wicomico Hospice at the Lake roastal If Under 1 Year | If Under 24 Ars. Security Numbe Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 71 406-44-1520 Director 11/7/1935 Kentucky Usual Residence of Decedent 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f shit be notified a 1 ¥Yes 2 □ No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 209 W. Philadelphia Ave. 21801 USA "natural", or Items 23a Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Maryland State than, Elementary/Secondary (0-12) College (1-4or 5+) Highway Commission 12 Consultant 12 should be filed whand Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Cushey Arlie Carter Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m 209 W. Philadelphia Ave., Salisbury, MD 21801 Beth B. Hughes/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/25/07 Salisbury Crematory Salisbury, MD injury o 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Ē 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ancretic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of Examiner burial-transit Due to (or as a consequence of) Box 68760 attending physician pe Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9∏Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed Was all, autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examine Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manner of Ceath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Natural

Accident (Month, Day Year Injury 5 Pending investigation To the Hospital or Attendir zwithin 24 hours after death. To the Funeral Director: At 2 completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 2 6 2007

aug

Begistrar's Signature

Coastal Hoste

cause of death (Item 23a) (Type, Print)

026278

PO Box 1733

#### 07-05612

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State of Maryland	Department of	Health and	Mental Hygiene

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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Ì	20a. Method of Di	sposition		Romoval from			position (Na			Da 7/26/			LAND		ie.
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8760,	ate be executed mysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a conseq SEFS as a conseq as a conseq	uence of):	سند	do	)54	ع			(	UWKH NGEP NGE	Och Och Och Och
Box 6	ne death cartific the attending pl thed for usa as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic production of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the cont						ate of delivionth	•	ear
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	By		30. Name and address of person Samuel Kleiman, M.				Print)								,
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 4:38 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Рм August 1, Richard Joseph Ince, Jr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's Hospital St. Mary's Leonardtown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 22,1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 ★ M 2 🗆 F 63 217-42-0348 Wisconsin Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland St. Marv's Scotland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11880 Point Lookout Road 20687 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Owner/Operator Marine Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Joseph Ince, Sr. Helen Jo Ann Gorton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 358, Hollywood, Maryland 20636 Norma Gene Ince / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Thichael P.O. Box 270, Leonardtown, Maryland 20650 23a. Part. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final a.tata cardiac aysthythmia minutes disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe Yes 2 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

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Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran page 2 director,

Physician/Medical Examiner Completed by Medical Certification: To Be

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State Registrar

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6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

29c. License number D0064519

Leonardtown

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

August 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX

GOVERN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 07 29 2007 1850 **JACKSON** NELSIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Year Months Days Hours 1 □ M 2 🕅 F 95 Yrs Director 234-16-9674 29,1912 Jan. Hampshire Co.WV Usual Residence of Decedent the Maryland 10c City Town or Location a or 28a-f show be notified at 10b. County 10d. Inside City Limits 1 XiYes 2 □ No Director WV Mineral Keyser 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code items 23a inner must b 500 Carskadon Lane, Apt. 301 by Funeral 26726 USA Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💥 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Hospital 7 Is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental ပ Asa G. Hott Lula M. Nealis 19a. Informant's Name/Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heath at
Important; If item 27 Is
any Injury or other trau Carla Clark/ Niece 13524 Poppy Street Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State August 3 4 ☐ Donation 5 ☐ Other (Specify) Headsville Cemetery 2007 Headsville, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronar resulting in death) /Medical Due to (or as a consequent of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed n 24 hours after death. The Funeral Director: A pletely filled in by the fu within 2

Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tain MR nou trostburg -31. Date filed (Month, Day, Year) State AUG 0 8 2007 Registrar

and manner stated.

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #5 8/1/07 07-05665 State of Maryland / Department of Health and Mental Hygiene John Carlson Justice, 3rd CCHD, rvt Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Da July 24, 2007 Year 0210 hrs Medical Examiner John Carson Justice, III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Shock Trauma Center **Baltimore** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 216-98-4214 216-98-2779 If Under 1 Year 7. Age (In vrs. last birthday) 6 Sex **Funeral** Foreign Maryland Country) Months Days Hours Min. Director May 11, 1979 1X M 2 F Yrs 2.8 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 1 X Yes 2 No 28a-f show Port Deposit 23a or 28a-f shoy notified at once Cecil Maryland death with the Maryland Director 10f, Zip Code 10g. Citizen of What Country 10e. Street and Number 21904 U.S.A. 155 North Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. must be White, etc. Armed Forces' 1 Never Married 2 X Married Yes or White . Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Teat. If item 27 is marked other than "natural", or of other traumaitic event, the Medical Examiner. Yes 2 X No specify: Specify: Yes, Give Yes 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Creeger's Hardware Elementary/Secondary (0-12) College (1-4 or 5+) Rising Sun, Maryland 21215-0036 Heavy Equipment Operator Nine Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sheila Davenport John Carson Justice, Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 21904 155 North Main Street, Port Deposit, MD Penny Ann Murray-Justice (wife) Baltimore, MD Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 07/29/07 West Chester, Pennsylvania R.A. Ferris & Co., Inc. Donation 5 Other Specify 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. onature of Funeral Service Licensee 21. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician for use as the burial -Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 death o 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has performed? death? Yes 2 V No Yes No The 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA this 1 🗸 Yes 28a. Date of Injury Jul 24, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: Subject struck by train 0210 hrs Natural Pending Yes 2 ✔ No Director: d in by the f Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State)
Railroad track to rear of 155 N. Main St, Port Deposit, M (Specify) Railroad Tracks 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an July 25, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur, State Registrar

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ž	should ind Men marke umatic	P L	Walter R. Jewel  19a. Informant's Name/Relationsh		405 44-17		Elizabe			
Maryland	and 2 sho Balth and n 27 ie m		Gay A. Leedie/d			shford Dr.			City or Town, State, Z 278	ip Code)
Je,	item		20a. Method of Disposition		20b. Place of Dispo				0c. Location - City or	Town, State
<u><u>E</u></u>	Pages ment of I		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp.			y Cremato	· 1	/07	Salisbury	, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		21. Signature of Funeral Service L	icensee	CESP 2	Name and Address	of Facility Luneral H	lome1:Pro	fessional ry, MD 218	Association
A.	*		23a. Part 1. Enter the disease, or o shock, or heart failure. List o	complications that cause						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Thy one cause on each	Lun					Onset and Death
1	/Medical		resulting in death)	Due to (or as	a consequence of):	g lancer ascrib				
	Examiner		Sequentially list conditions	b		ALWD				
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
	and and I-trans	каш	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):		· · · · · · · · · · · · · · · · · · ·			····
68760,	icate be executed physicien and s the burial-transit			Due to (or as	a consequence or,					
587	ifficate g phys as the	edicai		d						
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and ral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deli	/erv
m.	death e ette d for	Physician/M	in the past 12 months?	4☐Pregnant at		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0	that the ded by the detached	hys	9 □ Unknown	9L] Unknown						
	signed be det	by P	Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	w require been si should l	ted						1 Tes	2 No 3 Pro	bably 4 Unknown
ecc	e law r has be ge 2 sh	Completed				- · · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy		opsy findings available ompletion of cause of
<u>=</u>	The cate h	Con						perform	ed? death?	2 No
Vita	ician: Th	Be	25. Was case referred to medical examiner?	. La anitati			26. Place of Death	(Check only one	)	
of	Physic this cal dir	2	1 Yes 2 No	Hospital:			4   Itursing Ho		nce 6 ☐ Other (Spec	ify)
u	ding h. After funera	ion	27. Manner of Death 1 Natural 5 ☐ Pending		lry Year) 28b. Time o	Works	at P es 2 □ No	28d. Describe hov	v injury occurred	
Division	or Attending Physicien: The after death.  Director: After this certificate his in by the funeral director, page	fica	2 Accident investiga 3 Suicide 6 Could no	ot be 390 Place of Ini	jury - At home, larm, st			281. Location /Stre	et and Number or Ru	ral Route Number
Š	al or / s after il Dire	Certification:	4 Homicide determin	building, et	c. (Specify)	out, ractory, office		City or Town,		ar the allo real moon,
	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	Fo the	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Month	, Day, Year)
	Q12		Maken			7 4	7094		7/24/0-	7
•	JO2		30. Name and address of person w	no completed cause of c	leath (Item 23a) (Type,	Print)			1 110	
	10		Vel NATERAN		15 5. Di	v sheer	Sulish	ury 1	mp 2150	<i>t</i>
	Sta Registr	Ja	31. Date filed (Month, Day, Year)  JUL 2 6	1997	rar's Signature	ade)				

1XX ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

SOUTHERN AVE. SE WASHINGTON,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D42955

29d. Date signed (Month, Day, Year)

7/23/07

DC 20032 #210

Division or Vital Records, P.O. Box 68760. attending physician death.

with the Maryland

Saltimore, Maryland 21215-0036

I or Attending lafter death. Director: within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2 6 2007

POTTER 1328

29a. Certifier

(Check only one)

**EDGER** 

29b. Signature and litle of certifie

30. Name and address of pe son who comple

Medical

32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 06:05 PM July Harold Miles Gorsuch Keech 28, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2507 Thornberry Dr. Edgewood Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 MM 2 □ F 68 Yrs 10, 1939 Maryland Director 220-34-6356 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Funeral Director Maryland Harkord Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 u.s.A. 2507 Thornberry 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Affried Folices: 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1957–78 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Marines Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold James Keech Helen C. Cole Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 I 606 Snowgoose Ct. Havre de Grace, Maryland 21078 Gregory Scott Keech 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Jessop Methodist Cem. 08/02/2007 | Sparks, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Lees manimutchell Smith Funcial Home 21. Signature of Funeral Service Linens 123 S. Washington St. Havre de Gace, MD 21078 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CANCER CUNS disease or condition resulting in death) YEAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Division or Vital Records, P.O. Box 68760, £ attending physician and use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

401 North

Registrar's Signature

KeithW PRATZMP

31. Date filed (Month, Day, Year)

P066343

BROADWAY, BALTIMORE MD 21231

JULU 31, 2007

			1 - State of Maryland / Department	artment of Health and M		ene	251,32
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Vass	3. Time of Death
	Physici /Medic		Ruth Rebecca Kyle		July 24	1, 2007	0910 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			Laurelwood Care Center	Elkton		Ce	cil
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director	Ė	212-50-3211 1□M 2\(\text{\Omega}\)F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) March 7,	1925 Ma	aryland
	p		Usual Residence of Decedent				
	how		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f s	cto	Maryland Cecil	Port Deposit			1 Yes 2X No
	or 28	Directo	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	untry?
	death with the Maryland ma 23a or 28a-f show Crives be notified at	<u>a</u>	52 Maple Hill Drive	21904		U.S.	. A .
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
٥	or Its		1 Never Married 2 Married 1 Yes 2 X No	1 ☐ Yes 2X No Specify:	riioun, dio.,	Black, White	s, etc.
2-003e	72 hours after natural", or ite	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	TEL 103 ZZE 110 Optiony.		Specify: W	hite
	72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work	ang 16	6b. Kind of Business/	Industry
V	within ene. than "	ф	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
V	e filed within al Hygiene. I other than "		Twelve Years	Homemaker	- 15		Residence
yland	uld be fi dental P rked of tic ever	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	,	
Ž	should ind Men ind marke imaric	To	Robert Marshall Baird, Sr.		essie Bla		
Z	2 sh and raun			ng Address <i>(Street and Number or Run</i> Chestnut Drive, Ell		•	
a)	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I Health and Mental Hyglene are trained at 1884 a show item 27 Is marked other than "natural," or Itema 28a or 28a-f show ither traumatic event, the Moulcal Examiner must be notified at						921
0	Pages 1 nent of 1- int: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cref	matory or other place)		c. Location - City or	Iown, State
E	tmen tant: jury				27/07 Po	ort Deposi	t, Maryland
n n	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		ballones he bassass St	2. Name and Address of Facility Lee A. Patterson & Perryville, Maryla	Son Fund	eral Home,	P.A.
****	4		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate
	Physician		Immediate Cause (Final	TERROLL			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. // YOU DIFF  Due to (or as a consequence of):	INFORETION			
	Examiner		(FOERAM	VASCULAR DIS	SANE	ĺ	
ų	* **	Je.	if any, leading to immediate Due to (or as a consequence of):				
	cuted nd ransil	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	Foulkation			
Ś	be executed Icien and burial-transit	Ĕ	resulting in death) Last Due to (or as a consequence of):				
20/0	ate be executed hysicien and the burial-transit	cai	d				
Ď	leath certifica attending ph I for use as th	led	(F. FFAAA) F.				
Š	th cer endir r use	an/	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	∃Ectopic pregnancy		23d. Date of deli	
-	dea de ati	sicia	1 Yes 2 No	Other (specify)		Month	Day Year
ر ر	at the	Physician/Med	3 🗆 Ouknown				
ń	The law requires that the death certificate site hes been signed by the attending phys page 2 should be detached for use as the	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to	
coras,	equir	ted			1 ☐ Yes	2 No 3 □ Pro	obably 4 Unknown
ວັ	law r es be 2 sh	pie			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	sician: The lar certificete hes rector, page 2	Completed			performe	d? death? No 1 ☐ Yes	
<u> </u>	artific ctor,	Be	25. Was case referred to medical examiner?	26. Place of Deat	h Check only one		-
5	hysical dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: Nursing Ho	ome 5 Residen	ce 6 □Other (Spec	cify)
	ng P	ë.	27. Manner of Death 1 □Natural 5 □ Pending 28a. Date of Injury (Nonth, Day Year) Injury	f 28c. Injury at Work?	28d. Describe how	injury occurred	
2	endi eath. or: A	ati	2 Accident investigation	M 1 Yes 2 No			
2	or Att after d Direct in by	Certification:	3 Suicide 6 Could not be determined 28/. Place of I flury - At home, farm, str building, stc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier  (Check only  29a. Medical Exeminer: On the best of my knowledge, deat	h occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated.
	the H in 24 the F iplete	ledicai	one) and manner stated.				
	To To	Σ	29b. Signature and title of certifi if	29c. License number		I. Date signed (Month	
			/////8/12	U37017	4	7100	1
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	- 1	NEW	07 (ASTIE DE 1972
			ALCUSTY South May Year 1		CUAN C	152	19120
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ale			

			For	State of Marylan	•			l Mental Hy	giene		
			State Registrar		Cei	rtificate of	Death		Reg. No.		
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Year	e of Death
	/Medic		Balajeh	Kashef		# 01 T	- Lord's - / Do	7	23 20	007 003	35 a <sup>M</sup>
). 	Examin	er	4a. Facility Name (If not institution, give	, , , , , , , , , , , , , , , , , , ,			or Location of De	am	4c. County of		
	Foreset	4	Shady Grove H  5. Social Security Number 6. S		last birthday)	Rockv: If Under 1 Year		rs. 8. Date of Bir	th	gomery  9. Birthplace (State	te or Foreian
	Funeral Director		-	□M 2対F 85	Yrs.	Months Days	Hours Mi		ay, Year)	Country) ` ran	
	70		Usual Residence of Decedent				<u> </u>	11/23/	1922 1		
	arylar show dat	-	Md. 10b. County Md. Montgo		y, Town or Lo ntgome		llage				e City Limits es 2 🕅 No
	he Ma :8a-f	ecto		mery Mon	regome		age	1			C3 244110
	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 10024 Stedwick	Rd. #301		10f. Zip Code 208	86		10g. Citizen of Wh	,	
	eath ns 23 musi	eral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Was Decedent of I	Hispanic Origin?	(Specify Yes or No		American Indian,	1
0	riter or iter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No				(Specify Yes or No erto Rican, etc.)		, White, etc.	
21215-0036	ours a ral", o Exan	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify:	white	
بر م	72 hc natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of Busi	iness/Industry	
7	ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)			ed)		Home		
Z	iled v dygie ther t		7 17. Father's Name (First, Middle, Last)	)	пон	nemaker	18 Mother's N	ame (First Middle	, Maiden Surname,	)	
an	be ad a	Be C	Assad Kashef				Zahr			,	
Maryland	s 1 and 2 should I of Health and Men item 27 is marker other traumatic	To	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	t and Number or	Rural Route Numb	er, City or Town, S	tate, Zip Code)	Md.208
	1 and 2. Health a: tem 27 is		Gholamreza Sam	ini- son					Montgom		
Ğ.	of Her		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location - C	ity or Town, State	
Ĕ	Pages ment of P ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	rkĺaw	n Cemet	ery 7/	25/07	Rockvi	lle, Mo	i.
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Lige	1598 A	I	2. Name and Addre			al Mort		
П	2018		1 Luch	/ will					Washing		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	h. Do not ent	er the mode of dyi	ing, such as card	iac or respiratory a	arrest,	Approxir Interval I Onset ar	nate Between nd Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			ary Ede	ema				
1	/Medical Examiner		1	Due to (or as a consequence Congesti		loart I	Failure				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ		leart I	allule			+	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Acute My	ocard	lial Ini	farctio	n			
'n	exec an an rial-tr	Еха	resulting in death) Last	Due to (or as a consequ	uence of):						
8/60,	ficate be executed physician and s the burial-transit	dical	•	d							
9	ertifica ing ph e as t	Med	IF FEMALE:								
X Q Q	the death certific y the attending p ched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1☐Live birth 2☐Feta	Ideath 3	Ectopic pregnanc	Э		23d. Date Mont	of delivery th Day	Year
	he de the a	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5L	Other (specify) _				,	
1			Part II. Other significant conditions of	contributing to death but not resi	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use contrib	oute to the cause	of death?
Vital Records,	The law requires that te has been signed boage 2 should be deta	d by	Coronary Ar	tery Diseas	se			1 🗆	Yes 2 X No 3	∃ Probably 4	□Unknown
င္ပ	w rec	lete	Dementia					24a. Was	an 24b. W	ere autopsy findin	gs available
2	The la te has age 2	Completed	Demenera						psy pri prmed? de	ior to completion o eath? ⊒Yes 2 <b>⊠</b> No	of cause of
<u>a</u>		Be C	25. Was case referred to medical				26. Place of D	1  Yes Death (Check only o		1163 263140	
o .	Physician: this certificatal director, I	To B	examiner? 1 ☐ Yes 2 <b>K</b> No	Hospital: 1 Hospital: 2 -	ER/Outpatier	nt 3□ DOA Ot	her: 4 \( \sum \) Nursing	Home 5□Res	idence 6 □Other	(Specify)	
0	ding Phys h. After this funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju	ıry at ork?	28d. Describe	how injury occurred	d	
<u> </u>	tendi eath. for: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No				
UIVISION	or At offer d Direct in by	Certification:	4 ☐ Homicide determined		ome, farm, str y)	eet, factory, office			Street and Number wn, State)	or Rural Route N	lumber,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a, Certifier 1 Certifying Ph	nysician: To the best of my kno	wledge, deat	h occurred at the t	ime, date and nis	ace, and due to the	cause(s) and man	ner as stated	
	e Hos 24 hr e Fun etely	Medical		miner: On the basis of examina and manner stated.							se(s)
	To the within To the Somple	Me	29b. Signature and title of certifier	-/			se number		29d. Date signed		r)
)	10		1 53Ec	CUN V	V(2	D006	2435		7/23/2	007	
	(60)		30. Name and address of person who								
			Sayed Eisayya	d 9715 Medic	al Ce	nter Dr	. Rock	ville, I	Md. 208	5 U 	
Lig	Sta Registr		31 JUL fil 2 (5 2007 Year)	32. Registrar's Signa	ture			•			

DHMH 17 Rev 1/2001

			For State of Ma  State of Ma Registrar	ryland / Dep <i>Ce</i>	artment of H rtificate of L			JIENE Reg. No.		M S
0.45			Decedent's Name (First, Middle, Last)				2. Date of Dea		3.	Time of Death
	Physicia		III 1 A IZ-1				Month Ju1v		Year 1007	12:25P <sup>M</sup>
Se.	/Medic		Thelma A. King  4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death		4c. County o		14:431
,	Examin	eı	Southern Maryland Hospit	.1		Clinton		Dri	nao C	eorge's
×.	Funcion	X.		a⊥ (In yrs. last birthday,			8. Date of Birth	1	9. Birthplace	(State or Foreign
	Funeral Director		578-54-4585 <b>-</b> A 1□M 2□₹	93 Yrs.	Months Days	Hours Min.	May 30,	, Year)	Country)	. , DC
81	<u> </u>		Usual Residence of Decedent	73			may Ju,	1714	Wasii	, DC
	yland now at		10a. State 10b. County	10c. City, Town or L	ocation				10d.	Inside City Limits
	Mar a-f st fied	혅	Maryland Prince George's		Unn	er Marlbo	aro			1∏Yes 2□No
	n the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of WI	nat Country?	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show sdical Examiner must be notified at		16300 Brook Trail Court			20772		Unit	ed Sta	ates
	deat ms 2 r mu	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specity Cuba		pecify Yes or No-		- American I	
9	after or ite		1 Never Married 2 Married 1 Yes, Give	o	1 ☐ Yes 2 ∏ No	Specify:	nican, etc.		White, etc.	
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5-003	72 hc natu lical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa	ation during most of work	dina I	16b. Kind of Bus	iness/Indust	ry
7	within 72 ene. than "na' he Medic	ng l	Elementary/Secondary (0-12) College (1-4or 5+	) life.	e kind of work done o DO NOT use retired	)				
7	filed wi Hygier other th	So	12th	Natio	nal Educa				rivate	2
5	tal Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III al Hyller III a	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			,	
Maryland 2	ould be Mental arked c	မ	Richard Hawkins				Alberi	ta (Unkn	own)	
<u>a</u>	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, S	tate, Zip Cod	de)
	and ealth 7 27 rer tr		Alfred A. Hawkins/Nephew	16	300 Brook osition (Name of	Trail Ct	., Uppe	r Marlbo	ro, MI	20772
9	ges 1 t of H If iter or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disponentery, cre	osition (Name of ematory or other plac	e)	Date	20c. Location - C	ity or Town,	State
Baltimore,	Pa nen int:		4 Donation 5 D Other (Specify)	Ft. Line	oln Cemet	ery 7/27	1		wood,	MD
ä	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	2	2. Name and Addres	*		Funeral	Home	
n	82 5 2 5		John 1. Sheward	, 11		Benning F	-	Wash.,	DC 200	)19
			23a. Part1. Enter the disease, or complications that caused t shock, wheart failure. List only one cause on each line	he death. Do not en	iter the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Inte	proximate erval Between
	Physician			cardial	In far				On	nset and Death
1	/Medical			consequence of):	111 3 501	CIIOI				
	Examiner		Sequentially list conditions, b.							
	p #	ner	flia by leading to in modicitie Due to (or as a cause. Enter Underlying	consequence of):						
	ocute nd trans	Examiner	Cause (Disease or injury that initiated events c.							
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X Q Q	death cert e attendin d for use	an/l	23b. Was decedent pregnant 1 Live birth 2	PEtal death 3	□Ectopic pregnancy	,		23d. Date Mon	of delivery th Day	y Year
0	e des he at ied fc	sici	1 Yes 2 No 4 Pregnant at t	ime of death 5	Other (specify)			WIOTI	ui Day	, real
٠	at th	Physician/M	9 Unknowh	and the state of the state of		- '- D	00 - Did t-	bacco use contril		
<u>v</u>	w requires that the death certil been signed by the attending should be detached for use a	þ	Part II. Other significant conditions contributing to death but	-	andenying cause give	en in Part I.				
כ	requi	Completed	Renal Insufficience	<del>}</del>			1 U Y	es 2 No :	S Probably	y 4 □Unknown
ပ္	e law has b	ple	Azotemia				24a. Was a		ere autopsy ior to comple	findings available etion of cause of
r	ate Dag	5	·				perfor 1□ Yes		eath? □Yes 2	<b>√</b> No
VIта! Жесого	sian: ertific ctor,	Be (	25. Was case referred to medical examiner?			26. Place of Deal	th (Check only or	ne)		1
<u>-</u>	ding Physlcian: Th. n. After this certificate funeral director, pag	0	1 ☐ Yes 2 No Hospital: 1 Inpatien	t 2 ER/Outpatie	nt 3□ DOA Othe	er: 4 ☐ Nursing Ho	ome 5 Resid	ence 6 DOthe	(Specify)	
0	ng Pl fter t	ä	27. Manner of Death  1 ★Natural 5 □ Pending  28a. Date of Injury  (Month, Day)		of 28c. Injur Worl	y at k?	28d. Describe h	ow injury occurre	d	
0	eridii safh. or A he fu	äţic	2 Accident investigation			Yes 2 □ No				
INISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injurbuilding, etc.	y - At home, farm, st <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Town	treet and Numbern, State)	r or Rural Ro	oute Number,
3	ital o rs aff ral D	Ce								
	Pospital or Attending Physician: 24 hours after dealh. 5 Funeral Director. After this certifica etely filled in by the funeral director, t	edical	29a. Certifier (Check only Medical Examiner: On the basis of	examination and/or in	th occurred at the tin	ne, date and place	, and due to the o	cause(s) and man	ner as state	d. e cause(s)
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director completely filled in by the	ledi	one) and manner stat	ed.						
	viti To	Σ	29b. Signature and title of certifie		29c. License		1	29d. Date signed		
_			M. Transessed dy			5299	4	1/2	12	007
D	(2)		30. Name nd address of person who completed cause of de	ath (Item 23a) (Type	, Print)	1000.0	705	CLINITA	ni na	10 9072
	- 19	G 1	ALI RAHIMIAN MO 31. Date filed (Month, Day, Year) 32. Registrar	750) S(	DERATTS	KUAD	507	0011010	10 1 1(	1740 /31
	Sta Registr		31. Date filed (Month, Day, Year)	's Signatur (144)						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#20b, perFH, 7/31/07, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $p^{M}$ Hans Elmar 18, 2007 Kaiser July 7:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hillhaven Nursing Home Adelphi Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sev 7. Age (In yrs. last birthdav) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Year 1 X M 2 T F Yrs. 058-36-1453 79 Feb. 1928 Czechoslovakia Director 16, Usual Residence of Decedent r must be notified 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring the 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 1 433 Southwest Drive 20906 Funeral Germany death items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☒ No Specify: \$ Specify: 3 Widowed 4 Divorced Caucasian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "any Injury or other traumatic event, the Meaonce. Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolf Kaiser Charlotte Thiel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sigrid Haines / Guardian Bethesda Metro Center, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Unit 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/31/2007 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funerati Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part<sup>1</sup>, E. ler the disease, or o plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho, k, o heart failure. List nly one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final **Physician** Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 1 Tes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy
performed?

1 Yes 2 X No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4N Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this To the Hospitan c. . . . . . . . . . . within 24 hours after death.

To the Funeral Director: After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Lawer,

Maryland 21215-0036

3altimore,

DHMH 17 Rev 1/2001

State Registrar

Medical

Thomas E. Maslen, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Drive, Greenbelt, Maryland 20770

and manner stated.

29a, Certifier

(Check only one)

29b. Signature and title o

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D55559

29c. License number

29d. Date signed (Month, Day, Year)

July 23, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July Dorothea Koppke 20 2007 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cherry Lane Nursing Center Prince George's Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 6. Sex Months Days Hours Min 1□M 2\TF Yrs. Director 578-52-8211 86 1920 Germany Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or Items 23a or 28e-f ehow vent, the Madical Examiner must be notified at 1 X Yes 2 No Directo Maryland | Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 9001 Cherry Lane 20708 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No German Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be fill politiment of Health and Mental H portant: If item 27 Is marked ott y njury or other traumatic even Unknown Menna Koppke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rene Simpson/Daughter 503 Crest Lane Drive, Smyrna, GA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 7/26/2007 \_ Harmony Memorial Park Landover, MD Deputition of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of th 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home Lugary 4001 Benning Rd., NE Wash., DC 20019 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate cause (Final disease or condition resulting in death) **Physician** vanced /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last enria Examiner The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 ②No Month Day 4☐Pregnant at time of death Year 5 Other (specify) 9☐ Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown Completed 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 2 Accident Director 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide

To the Hospital within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

2 6 2007

NEO

29b. Signature and title of certifier

29a. Certifier

4000

person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number

### 07-05526

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Gregory	Tyrone	Lattisaw	

	Physicia		<ul> <li>For State</li> <li>Registrar</li> <li>Decedent's Name (First</li> </ul>	t, Middle,Last)		rtificate of	Death		2. Date of Death		3. Time of Death 0133 hrs
	al Examir	ner	GREGORY	Y TYRC	NE LATTISA	N			July 19, 20	07 4c. County of De	
			4a. Facility Name (if not in			[	4b. City, Town, or Mt. Rainier	Location of Dea	ath	Prince Geor	
			Queens Chapel			last hirthday)	If Under 1 Yea	r If Under 24h	Hrs. 8. Date of Birth	n(MM/DD/YYYY) 9.	Birthplace (State or
	Funeral Director		5. Social Security Number	99 1xx	M 2 F 22	Yrs	Months Day		Min. 12/3/	For	eignWASHINGTO Country
	÷	1	Usual Residence of Dece 10a. State 10b. 0	County	10c. City	y, Town or Locat	ion				10d. Inside City Limits
	10wai	١. ا			GEORGES	ТЕМРТЛ	E HILLS				1 X Yes 2 No
	daryland 28a-f show any d at once.	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	country?
	h the Maryland 3a or 28a-f sho	ä	2403 SOL	JTHERN	AVE. #303		20745			U.S.A.	
	and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f ake tranmatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2	2 Married	12. Was Decedent Ever in Armed Forces?  1 Yes 2X No	If Y	es, specify Cuba	n, Mexican, Pue	( Specify Yes or No- erto Rican, etc.)	White, etc	nerican Indian, Black, c. BLACK
	after d	by F	3 Widowed 4		If Yes, Give Year	1	Yes 2X N		of work done	Specify: 16b. Kind of Busine	es/Industry
	natur	leted t			ly highest grade completed)	16a. Decede during n	nt's Usual Occupa nost of working lif	e. DO NOT use	retired)	TOD. KING OF BUSINE	33/Hudotty
5-0036	uld be filed within 72 i Mental Hygiene. marked other than ", c event, the Medical E	Complet	Elementary/Secondary		College (1-4 or 5+)	PAT	ENT TR		RTATION		UNIV. HOSI
15-(	filed vide of the other of the other the	ပိ	17. Father's Name (First, KEVIN T.		T C 7 W				ARA A. H.		
2121	Menta marke even	To Be	19a. Informant's Name/R					et and Number	or Rural Route Num	ber, City or Town, S	state, Zip (Apps) 2074
MD.	2 shour and 1 and 27 is matic	_			KINS/MOTHER	2312	W. RO	SECROF		GE CIRCI	E OXON HILI
Baltimore, N	permt. Pages I and 2 should be fi Department of Heath and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Dispositi	remation 3	Removal from State	o. Place of Dispo crematory or c ESURRE (	sition (Name of c ther place) CTION C	emetery, EM .	Date 7/24/07	20c. Location - Cit	
İŧi	artme ortan		4 Donation 5 0	Other Specify.		22.	Name and Addre	ss of Facility			RAL SERVICE
å	Dep Dep		Komyad	1 8to	wast	65	00 ALL	ENTOWN	RD. CA	MP SPRIN	IGS , MD 2074 Approximate Interval
	hysician		23a. Part Enter the dis	ease, or comp	lications that caused the dea ach line.	ith. Do not enter	the mode of dyin	g, such as cardi	ac or respiratory arr	est, snock, or near	Between Onset and Death
	xaminer		Immediate Cause (Final	disease a.	Head and Neck Injuri	es					- Doutin
			or condition resulting in	dealin)	Due to (or as a consequence	e or):					
		ē	Sequentially list condition if any, leading to immed	tiate	Due to (or as a consequence	e of):					
		Examiner	cause. Enter Underlyin (Disease or injury that in	nitiated C.	Due to (or as a consequence	e of):					
	ted d ansit	lй	events resulting in deat	n) Last d.							
	execu an and al - tra	ical	UNPENDED		AMENDED						
60.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE:		23c. If yes, outcome of p	regnancy				23d. Date of de	- V
687	ertific ding p	jan/	23b. Was decedent preg past 12 months?	nant in the	1 Live birth  Pregnant at time of	de este	Fetal death Other (Specify)	3 Ectopic pr	regnancy	Month	Day Year
č	leath c e atten for us	Physician/	1 Yes 2 No 9	Unknow	7	3	Other (Specify)				
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۵	ires that the signed by	. –							_		Probably 4 Unknown
ds	w requir	Completed	0						24a. Was	psy prid	ere autopsy findings available or to completion of cause of
O	te has	ह							1 <b>✓</b> Yes		eth? Yes 2 No
ă	in: Ti rtifica tor, pa	ြပ္မ		to medical			26.Pl	ace of Death (C	heck only one)		
Z.	VILO ysicia this ce direc	To Be	examiner?	No	Hospital: 1 Inpatient 2				Nursing Home 5	Residence 6 🗸	
Ť	ing Physician: The l After this certificate I uneral director, page				28a. Date of Injury (Month, Day Year) Jul 19, 2007	28b. Time o	··· / /   _	njury at Work? Yes 2 ✔ N	Passenger	how injury occurred auto fixed obje	ct collision
į	ttendi feath. for:	] ∺	1 Natural 5	Pending Investiga	tion				_ 1	(Street and Number	or Rural Route Number, City
<u> </u>	lor A after of Direct	Certification:	3 Suicide 6	Could no determine	t be			e pulluling, etc.	or Town	State\	nan St., Mt. Rainier, MD
ב	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	ق ا			ed (Specify) Major R			date and place			
	he Ho in 24 he Fu	3	29a. Certifier 1 Cell (Check only one) 2 Me	rtifying Physi dical Examin	er:On the basis of examination	on and/or investi	gation, in my opir	nion, death occu	urred at the time, dat	e and place, and du	e to the cause(s)
	To t with To t	Medical	29b. Signature and title		and manner stated.			ense number			(Month, Day, Year)
			1 1	Me	ef mo		0.	C.M.E.		July 19, 200	7
5	1		30. Name and address	of person who	completed cause of death (	Item 23a)					
K	13)	ĺ	Tasha Greenb	erg MD.	Assistant Medical Ex	aminer 1	11 Penn Stre	et, Baltimore	e, MD 21201		
		Stat	2 31. Date filed (Month, 1	Day, Year)	32. Registrar's Sig	natural					

ORIGINAL

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of Hertificate of		Mental Hy	giene Reg. No.	n ta	2510)
	Dhuais		1. Decedent's Name (First, Middle	, Last)				2. Date of De	aath	Vane	3. Time of Death
	Physic /Medi		Joseph	G. Lov	itz			July	19,	2007	12:55 A M
	Examir	ner	4a. Facility Name (If not institution		er)	4b. City, Town, o			4c. County	of Death	
			Holy Cross  5. Social Security Number	Hospital 6. Sex 7.	Amo (In use Instituted		r Spring			ntgom	
ı	Funeral Director		138-03-2726	1 M 2 F	Age (In yrs. last birthda 89 Yrs.	Months Days	Hours Mir		av. Year)	9. Birthp Cour	lace (State or Foreign
			Usual Residence of Decedent	Λ	09			April	3, 1910	New	Jersey
	r 28a-f ehow	_	10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	8a-f	Director	Maryland Montg	omery	Wheator	1					1∏ Yes 2 No
	with th	P	10e. Street and Number	_		10f. Zip Code			10g. Citizen of		itry?
	eath ve 23g	Pra	2912 Fenimore R	load 12. Was Decede	et Francis (LC		902	2 4 4		S. A.	
30	be tiled within 72 hours atter death with the Maryland ital Hyglene. Id other than "natural", or iteme 23a or 28e-f ehow event, I'ra Medical Exaciliar must be rectified at	by Funeral	1 ☐ Never Married 2 ☐ Marri 3 🎖 Widowed 4 ☐ Divorced	Amed Force	s: WW 2	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	Specifi	e - Americ ck, White, v: $W$	
1215-0036	2 hou	ed	15. Decedent			cedent's Usual Occup	ation		16b. Kind of B	usingss/In/	fuetor
2	hin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4e	(Gi	ve kind of work done on DO NOT use retired	durina most of w	orking	TOD: KING OF D	2311103371110	addity
7	ad with	E	Elementary/Secondary (0-12)	2 Years		tographer			U.S.	Gove	rnment
land	d oth	Be (	17. Father's Name (First, Middle, I					ame (First, Middle		10)	
χ	2 should be tiled v n and Mental Hygie Is marked other raumatic event, ID	ို		itz			-	ellie Sa			
, Mar	and 2 sh salth and n 27 is m er traum		19a. Informant's Name/Relationsh Bonnie J. Berm		ter 2432	iling Address (Street Henslowe	and Number or F Drive,	Rural Route Numb Rockvi11	er, City or Town, .e, Mary	State, Zip Land	<sup>Code)</sup> 20854
Поге	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked ery Injury or other traumatic engage.		20a. Method of Disposition 1		te cemetery, c	position (Name of rematory or other place of Mem. Ge		Date 2/2007	20c. Location -		wn, State h, Virginia
baitimor	permit. Departm Importa eny inju		21. Signature of Funeral Service L	icensee	_	22. Name and Addres Danzansky 1170 Rock					- 0.0
Ī			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each	sed the death. Do not en line.	enter the mode of dyin	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		asepsis						
	Examiner		Sequentially list conditions		hydration						
	b #	iner	Sequentially list conditions, if any leading to him ediate cause. Enter Underlying Cause (Disease or injury	Drie to (or	as a consequence of):						
_	axecut and al-tran	Examiner	that initiated events resulting in death) Last		rdiac Arres as a consequence of):	st				-	
0,00	ate be executed hysician and the burial-transli	dicai E		d							
0	ntifica ng ph s as th	Medi	IF FEMALE:	1							
	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy				e of delive	,
5	the de / the a ched f	hysician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown	at time of death 5	Other (specify)			Мо	nui	Day Year
Ĺ	ures that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit	by Ph	Part II. Other significant condition		but not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?
ë 5	equire en sig ould b		Hematuria	<u> </u>				1 🗆 🕆	Yes 2X No	3 Prob	ably 4 □Unknown
ב ע	law r las be	Completed						24a. Was		Vere autop	sy findings available
= '	The cete h	Con							rmed?	leath?	2□ No
2 3	certition	Be	25. Was case referred to medical examiner?	Heaptel:		Ī ou		ath Check only o	ne)		
5	Phys this al dir	P	1 ☐ Yes 2 ☐XNo  27. Manner of Death	Hospital: 1 🔀 Inpa			4 🗀 Nursing i	Home 5 Resid			)
5	ding h. Atter funer	Fig	1   Natural 5 □ Pending		njury 28b. Time Day Year) Injury	Work	/at <br Yes 2 ∐ No	28d. Describe I	now injury occurr	ed	
2	Atten deat ctor: y the	ertification;	2 Accident investiga 3 Suicide 6 Could not determine	ot be Disco of	njury - At home, farm, s		163 2 110	28f. Location (5	Street and Numb	er or Rurai	Route Number
5	itel or ins after ret Dire	Certi	4 - Normicide	building,	etc. (Specify)		-	City or Tov	vn, State)		
:	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death: within 24 hours after death: To the Funeriet Director: After this certificate has been signed by the attending p completely tilled in by the funeral director, page 2 should be detached for use as:	Medical	29a. Certifier 1 XCertifying (Check only one) 2 Medical 8	y Physician: To the be xaminer: On the basis and manner	st of my knowledge, dea of examination and/or stated.	ath occurred at the tim investigation, in my of	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)
1	to t	Σ	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, L	Day, Year)
	15		Suar	ng la	J-	D60	826		July 20	, 200	)7
	, -		30. Name and address of person w Kshama Garg, N		f death (Item 23a) (Type Forest G1		ilver Si	pring. Ma	aryland	20910	)
	Sta	te	31. Date filed (Month, Day, Year).	32.	strar's Signature						
	Registr	ar	JUL 24	2007	w. K 1	La. 16 .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05592 State of Maryland / Department of Health and Mental Hygiene James Thomas O' Donnell Lee Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day July 21, 2007 0558 hrs Medical Examiner James Thomas O'Donnell Lee 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Laurel 10052 Washington Blvd 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min Months 03/07/1982 MD Country) 25 Director 214-11-3641 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location ì 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show : Greenbelt Prince George's Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f Zip Code 10e, Street and Number 20770 9-H Southway Rd 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 X No specify: If Yes, Give Year Divorced Widowed \$ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Construction Glazier 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jill O'Donnell Be James P. Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဥ Mother Greenbelt, MD 20770 9-H Southway Rd., Fitzmaurice O'Donne11 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/28/07 Brentwood, MD Ft. Lincoln Cem. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ft. Lincoln F. H. 3401 Bladensburg Rd., Brentwood, MD 20722 luas 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death **1**edical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical AMENDED attending physician for use as the burial UNPENDED 23d Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an s been should prior to completion of cause of autopsy death? performed? this certificate has 1 V Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Division of Vital Be Residence 6 🗸 Other: Scene Other<sub>4</sub> Hospital: 1 examiner? DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jul 21, 2007 28b. Time of Injury 27. Manner of Death Driver pick up fixed object collision Certification: 0550 hrs Yes 2 ✔ No Natural Director: Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 10052 Washington Blvd, Laurel, MD Could not be Suicide (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 21, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001 OCME 2000

State

OCME

Patricia Aronica-Pollak MD.

31. Date filed (Month Day Yes

**ORIGINAL** 

Assistant Medical Examiner

32. Registrar's Signatu

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician <u>5</u>:52 P <sup>M</sup> Ju1y 21 2007 Mitlehner /Medical Η. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7023 Rock Creek Drive Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 097-22-3748 1 X M 2 □ F 76 Director 25, 1930 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 7023 Rock Creek Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after eath and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔼 No þ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korea "natural" Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicall once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Educator Community College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Mitlehner Elizabeth Schmich 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Mitlehner / Wife 7023 Rock Creek Drive Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State July 24 2007 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility 21. Sign sture of uperal Service Licensee Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) nous /Medical Due to or as a consequence of): Examiner 0100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 one) and manner stated. 29b. Signatur 29d. Date signed (Month, Day, Year) d title of certifier HEGAZIMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drue Fredorich dhuson HEGAZI Thomas 46 31. Date filed (Month, Day, Year)

JUL 2 6 Registrar's Signature State 2007 Registrar

			1 - For State Registrar	State of Maryla		artment of I rtificate of			Reg. No.	07	2544
	Physic	ian	1. Decedent's Name (First, Middle, La	•				2. Date of Dea	Day	Year	3. Time of Death
	/Medi	cal	Florence M 4a. Facility Name (If not institution, give	Muller		45 00 7		July	24	2007	9:55 P
	Examir	ner	Lorien Mt. Air				or Location of Deat	n		ty of Death	7
	Funeral		5. Social Security Number 6. S	*	. last birthday)	If Under 1 Year		8. Date of Birt		Carrol	
	Director		003-10-5976	□M 2⊠F 85	Yrs.	Months Days	Hours Min.	June 16	, Year) • 1922	New	lace (State or Forei otry) Hampshire
	pu 🔹		Usual Residence of Decedent  10a. State 10b. County	100.0	ity. Town or Lo						
	sho	ò			,,					1	0d. Inside City Limit 1 ☐ Yes 2 ☒ N
	28e-1	Director	Maryland Freder:	ick	Monro	Via 10f. Zip Code			10g. Citizen of		
	With With			Jooda Dood							•
	death ms 2	Funeral	4996 Linganore W	12. Was Decedent Ever in I	J.S. 13. V	21770 Was Decedent of H		pecify Yes or No-		ed St	
21215-0036	72 hours after death with the Maryland "neturel", or Items 23e or 28e-1 show office! Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		fYes, specify Cub 1 ☐ Yes 2 🖾 No	Hispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Spec.	ack, White,	
Š	in 72 hor	Completed	15. Decedent's Ed	lucation	16a. Deced	ient's Usual Occup	pation		16b. Kind of I	Business/Inc	dustry
Z		ple	(Specify only highest gra	College (1-4or 5+)	life. I	NOT use retire	during most of word)	king			
7	T1 75	Sol	6		Seam	stress			Infa	nt Ho	me
ב	be filed Ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Suma	me)	
3	shoutd be nd Mental marked o	P	John Bergeron					seanna Ri			
Maryland	d2 ha 7 is		19a. Informant's Name/Relationship (7				and Number or Ru				
	1 an Heal em 2 ther	1 3	Jacalyn A. Robert  20a. Method of Disposition		4990 J	Jinganore sition (Name of	woods K	oad Mon	rovia,		and 21770
baltimore,	80=2		1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	1 tolloval from Otato	_	sition (Name of natory or other pla	ijuity	27,		,	
			21. Signature of Fun pulsar vice Licen	100		s Cath.		007	Norfol	k, Vii	rginia
ñ	permit. Departi Import eny inj	0	1 XUQ	to	16	21 Onoge	ess of Facility St.	ke Free	uneral	Mary	, P.A. land 2170
Г	- 44		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea						rial y.	Approximate
	Pnysician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	Bight Cel	rebal	. /	n Accid				Interval Between Onset and Death
	Examiner			This large	quence of):	rive					wk
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0	tificate be executed g physician and as the burial-transit	edical	•	d. Happer ?	ever.	en					7/
	eath certifi attending for use as		IF FEMALE:	23c. If yes, outcome of pregn	ancv				001.0		
DOX	death cer attendir d for use	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3 🗌	Ectopic pregnancy Other (specify)	1			ate of delive onth	ry Day Year
	that the de ned by the a detached f	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown							
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Š	aquire en sig	ed	Hyperlipiden	114				1 □ Ye	es 2 🗹 No	3 🗆 Proba	ably 4 □Unknown
necolds,	ne faw re has be ge 2 sho	plet	//					24a. Was a		Were autop	sy findings available
_	The ate h page	E C						autops perforr	ned?	death?	npletion of cause of 2 <b>⊠</b> No
VIII	cien: ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Dea	h (Check only on	-	, , , , ,	
5	shyei this c	은	1 ☐ Yes 2MC No		ER/Outpatient		4 Nursing Ho	ome 5 Reside	ence 6 □Otł	ner (Specify,	)
DIVISION OF	tending Physicien: The I leath. tor: After this certificate he the funeral director, page	on:	27. Manner of Death 1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		28d. Describe ho	w injury occur	red	
2	Nttendii death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of laive. At h			Yes 2 □ No	00(1) (0)			
2	I or Attency after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, tarm, stre fy)	et, factory, office		28f. Location (St City or Town	reet and Numl n, State)	per or Rural	Route Number,
-	To the Hospital or Attending Physicien: state as after death as a flet death To the Funerel Director: After this certifical completely filled in by the funeral director;	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my known iner: On the basis of examina	owledge, death	occurred at the tin	ne, date and place, pinion, death occur	and due to the ca	ause(s) and mate and place	anner as sta	ited. the cause(s)
	o the ithin i o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signe		
	⊢ ≯ <del>⊢</del> ŏ		1000-1	Kerlle 1	no	-					
	10		30. Name and address of person who c	ompleted cause or death (from	n 23al (Timo F	Print)	4749 use A	2	1019 2	10, 2	100/
	(3)		ALIEN Rei	1/4. MD 2	01 70	11/10	150 A	P TRA	Deei	ck	Md
	Sta	te '	31. Date filed (Month, Day, Year)	32. Registrar's Signa							8
	Registra	ar	nu 2.6	tone	H J	Sant 1					

DHMH 17 Rev 1/2001

			1 - State Registrar		Cei	tificate of	Death	Reg	J. No.	2564
	Physici	an	1. Decedent's Name (First, Middle, Last, Charles Jen	kins	Matting	lv Ir		2. Date of Death Month August	2° 2° 2° 2° 2° 2° 2° 2° 2° 2° 2° 2° 2° 2	3. Time of Death 1:35 P
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	Hatting	4b. City, Town, o	r Location of Death	August	4c. County of Death St. Ma	
-	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) October 23	(ear) 9. Birthp	place (State or Foreign
	Maryland f show ied at	tor	Usual Residence of Deccdent  10a. State 10b. County  Maryland St.	Mary's	10c. City, Town or Lo	cation Chaptico	)			10d. Inside City Limit
	h with the 23a or 28a st be notif	Funeral Director	10e. Street and Number 37750 Chaptico Roa	ad		10f. Zip Code	20621	100	g. Citizen of What Cour	ıtry?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any fining or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
0-01717	within 72 ho jene. r than 'natur the Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done i DO NOT use retired lesman	ation during most of worki d)	ing 16	Sb. Kind of Business/Inc	-
ylallu	ould be filed Mental Hyg iarked other atic event, i	To Be C	17. Father's Name (First, Middle, Last) Charles Jenkins M					Gertrude	Miles	
e, Mar	1 and 2 sh Health and em 27 Is m ther traum		19a. Informant's Name/Relationship (7). Charles Jenkins Ma		II   43121	Joy Lan	e Hollyw	ood, Mar	City or Town, State, Zip yland 20636 Oc. Location - City or To	6
	nit. Pages artment of hortant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		20b. Place of Dispo cemetery, crer Queen of Po		ry	. 7.	elen, Maryland	
מ	permit Depar Impor any ir	1	23a. Part 1. Enter the disease, or compl	Garden	en	Mattingley P.O. Box 2	-Gardiner F 70 Leonard	town, Maryl	land 20650	Approximate
	Physician /Medical Examiner	r	snock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence of):		Cardio			Interval Between Onset and Death
,00,00	ertificate be execute. Ing physician and e as the burial-tran- it	Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of):					
4	w requires that the death certificate be executes been signed by the attending physician and should be detached for use as the bunat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pl 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death 3☐	Ectopic pregnancy	,		23d. Date of delive Month	ery Day Year
colus, r	equires that en signed b ould be deta	by	Part II. Other significant conditions conditions		not resulting in the ur	nderlying cause giv	en in Part I.		cco use contribute to the	
מו חמני	To the Hospital or Attending Physician: The law requires that the death owithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for us	Completed						~	prior to cor	ppsy findings availab impletion of cause of 2 No
N VIII	h <b>ysicia</b> his certi I directo	To Be	25. Was case referred to medical examiner?  — 1  Yes 2 No	lospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Oth	26. Place of Deather: 4 Nursing Ho		ce 6 Other (Specif	· 5y)
2000	Attending P death. ctor: After I y the funera	Certification:	27. Manner of Death  1 Natural 5 Pending 24 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day 1	(Year) 28b. Time of Injury	M 1 🗆	Yes 2 □ No	28d. Describe how	injury occurred et and Number or Rura	ol Boute Number
Ś	ospital or a hours after meral Dire y filled in b		4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc.	(Specify) my knowledge, death	occurred at the tir	me, date and place,	City or Town, and due to the cau	State) use(s) and manner as s	stated.
	o the Huithin 24 of the Fu	Medical	(Check only 2 Medical Exami	ner: On the basis of e and manner state	examination and/or in	vestigation, in my o			e and place, and due to	
	1/1/		· my	m FA	no	DI	4285		8-2-0	_
	0.0		30. Name and address of person who co	mple d cause of dea	th (Item 23a) (Type,	Print) Wm. D	. Boyd, II,	M.D.	5	

Registrar

State

25365 Point Lookout Road

31. Date filed (Month, Day, Year)

AUG 0 3 2007

Leonardtown, Maryland 20650

Wm. D. Boyd, II, M.D.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Year **Physician** MONTEFERRARIO ADELINE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Under 1 Year IffUnder 24 Hrs. Days Hours Min. WICOMICO Regional Moderal 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at COUANTICO 1 ☐ Yes 2 No WICOMICO **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 054 STEPHEN FIELD LIN. A1865 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE ģ 3 Widowed 4 Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) COUNTED HOME n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKWOWN UNKNOWN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 180 Linealn AVE W. MILFORD N.S 07621 EDWAND MONTEFERNANIO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State -200 1 SALIBERY, MD DISEI SAKSBURY CREMITIONS 4 ☐ Donation 5 ☐ Other (Specify) and Advess of Facility SSUK FUNERAL HOME 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) and in pulmonary Due to (or as a ginsequence of): **Physician** /Medical Examiner 5 tag (or as a conseque of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 No 1□ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and tit

the

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29c, License number

SAlisbury Md.

29d. Date signed (Month, Day, Year)

0

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death

4b. City, Town, or Location of Death

3. Time of Death

Dav

July 20,

2007

4c. County of Death

	7209 Radnor Roa	d			Betl	resda				Мо	ntgo	merv	7	
		Sex	7. Age (In yrs.		(ay) If Unde	r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of B	irth		<ol><li>9. Birth</li></ol>	place (St	ate or Foreign
	577-30-1730	<b>№</b> □M 2□F	81	Yrs	3.			.,,,,,	Dec. 1				21	
	Usual Residence of Decedent		10.0											
_	10a. State 10b. County		10c. Ci	ty, Town o	r Location									de City Limits
Director	Maryland Montgome	erv	R	ethes	d a								1 🔀	Yes 2□No
ě	10e. Street and Number	y		Luico		p Code				10g. Cit	tizen of V	Vhat Cou	intry?	
	7200 D - 1 D	1												
Funeral	7209 Radnor Road		cedent Ever in U	.s.		0817	ispanic Or	iain? (Si	necify Yes or N		S.A. 14. Race	e - Ameri	ican India	n,
ä	1 □ Never Married 2 🖫 Married	Armed F		11	If Yes, spe	cify Cuba	ın, Mexica	n, Puert	pecify Yes or N o Rican, etc.)			k, White		
ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	iive		1 🗆 Yes	<b>2</b> □ No	Specify:				Specify		• •	
			Dates.	I 162 D	ecedent's Us	al Occup	otion			16h V	ind of Du		ite	
<u>e</u>	15. Decedent's (Specify only highest of	grade completed,	)	1 (G	ive kind of wife. DO NOT i	ork done d	durina mos	st of wor	king	16b. K	ind of Bu	isiness/ir	naustry	
ᇎ	Elementary/Secondary (0-12)		(1-4or 5+)											
Completed		2		Sal	es and	Mar					tomo:			
Be	17. Father's Name (First, Middle, La	st)					18. Moth	er's Nam	ne (First, Middle	e, Maiden	Surnam	ie)		
0	Jesse I. Miller	. Sr					F1or	ence	e Glas	er				
	19a. Informant's Name/Relationship	(Type. Print)		19b. M	ailing Addres	s (Street a			ral Route Num		or Town,	State, Zi	ip Code)	
	Ann Goldsmith M	Miller /	Wife	720	9 Radn	or R	d. Ro	the	sda, Ma	rv1 21	nd 20	0817		
	20a. Method of Disposition	111101 /	20b. F	Place of Di	sposition (Na	me of	i	CHE	Date Tia				own, Stat	te
	1 K Burial 2 □ Cremation 3		State	-	crematory or	•	í i					•		
	4 □ Donation 5 □ Other (Spe		Gar	rden	Of Rem	embr	ance	July	y 22,07 seph Ga	Cla	rksbı	urg,	Mary	yland
	21. Signature of Funeral Service Lic	ense												
	William V.	Dry	411	-	5130	Wisc	onsin	Ave	e. N.W.	Wash	n. D.	.C.	2001	5
	23a. Part1. Enter the dis-ase, or co shock, or heart failure. List on	mplications that	a ed the deat	h. Do not	enter the mo	de of dyin	g, such as	cardiac	or respiratory	arrest,			Approx	imate I Between
	Immediate Cause (Final		ertensi										Onset a	and Death
	disease or condition resulting in death)	u.	(or as a conseq			seas	e					-	10 Y	ears
		Due to	(or as a conseq	luence or).										
_	Sequentially list conditions,	b. — Duo to	(or as a conseq	ພາດກວດ ວຄະ								-		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that injury	Due to	(or as a conseq	juence oi).										
аш	that initiated events resulting in death) Last	c												
	resulting in death) Last	Due to	(or as a conseq	uence of):										
ca		d												
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3	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome pf pregna	ancy							23d. Date	e of deliv	/erv	
ä	in the past 12 months?		birth 2 Feta nant at time of c		3 ☐ Ectopic p 5 ☐ Other (s						Moi		Day	Year
/Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkr		ioatii	o⊟ other (a	becity)								
Ē	Part II. Other significant conditions	a a a márilm sáin a éa s					an in Dani I		00- Did	A=b==== :			41	-f -l +l- 0
by Physician/Medical	_		acam Dut not 162	wang na th	e undenying	ause give	an iii ran i	•		_	_			of death?
0	Prostatic Cano	er					<del></del>		1 🗆	Yes 2	<b>™</b> No	3 ☐ Pro	bably 4	1 ∐Unknown
Complete									24a. Was	s an	24b. V	Nere aut	opsy findi	ngs available
Ē									auto	opsy ormed?	l p	orior to co death?	ompletion	of cause of
									1□ Yes	2 X No			2□ No	
Be	25. Was case referred to medical examiner?	Haenital				0"		of Dea	th (Check only	one)				
2	1X Yes 2 No	1		ER/Outpa	tient 3 D		4 L N	rsing H	ome <b>N</b> Res	idence	6 □Othe	er (Speci	ify)	
tion:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date (Moi	of Injury nth, Day Year)	28b. Tim Inju	e of ry	28c. Injun Worl	/ at </td <td></td> <td>28d. Describe</td> <td>how inju</td> <td>ry occurr</td> <td>ed</td> <td></td> <td></td>		28d. Describe	how inju	ry occurr	ed		
ţ	2 Accident investigati	,	/		м		 Yes 2□	No						

1. Decedent's Name (First, Middle, Last)

I.

4a. Facility Name (If not institution, give street and number)

Miller, Jr

**Physician** 

/Medical

Examiner

23d. Date of delivery Month Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No No 6 ☐Other (Specify) injury occurred (Month, Day Year) Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) DC-MD 12568 July 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) New Mexico Ave NW Washington D.C. 20016 **ORIGINAL** 

State Registrar

12

Certification

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Thomas Socks MD 3301

6 ☐ Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ran Van Nguyen July 22, 2007 a M 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Hours 288-78-1713 Director 55 June 10, 1952 Vietnam Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 1 ☐ Yes 24 ☐ No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Lowander Lane 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten <u>ury</u> or other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ SpecifyAsian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Cafeteria 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Nguyen Bui Nguyen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Cay Thi Nguyen/Wife 804 Lowander Lane, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Julv 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring MD 20 enter the mode of dying, such as cardiac or respiratory arrest,

Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Gastric Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or inderlying Cause (Disease or injury that initiated events resulting in death) Last Ascites Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): sician a burial-Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 2x No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 1 Yes 2√ No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1X Natural Injury 5 Pending nours after death.

neral Director: Af
filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registra<u>r</u> Kanwaljit Nagi,

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Eleve It Specti

ORIGINAL

7010 Winterberry Lane, Bethesda, MD 20817

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

1. De	ecedent's Name	(First, Midd	lle, Last)								2. Date of De	_	V	3. Time of Death
Be	verly ]	acquel	line	Pater	5						July	30°,	2007	08:12 A
	acility Name (II		_							Location of Deat	h	4c. (	County of Dear	
	O Revol							Havre If Under 1		Grace	1		Harfor	
21.	3-30-51  I Residence of	26	6. Sex 1 □	M 2 <b>⊠</b> F	7. Age (	(In yrs. las			Days	Hours Min.	8. Date of Bir (Month, Da Aug. 1	ıv, Year)	Co	hplace (State or Fore ountry) <b>ryland</b>
	State	10b. County	y		1	Oc. City, 7	own or Lo	cation						10d. Inside City Limi
Ma	ryland	Harfe	ord			Hav	re de	Grace	_					1 <b>⊠</b> Yes 2 □ N
10e.	Street and Nur	nber						10f. Zip C	ode			10g. Citiz	en of What Co	puntry?
10	O Revol	ution	St.	Apt.	503			2107	8			u.s.	١.	
	Marital Status			12. Was De Armed F	orces?		13.	Was Deceder f Yes, specify	nt of His y Cubar	spanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)	)- 1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
	□ Never Marri			1 ☐ Yes If Yes, G Year or	2 🔼 No live Dates:			1∐Yes 21a	<b>₫</b> No	Specify:			Specify: 🕡	hite
	(Spec	15. Deceder ify only higher	nt's Educ est grade	ation completed	)		(Give	dent's Usual (	done di	uring most of wo	rking	16b. Kin	d of Business/	Industry
Ele	ementary/Seco	ndary (0-12)		College	(1-4or 5+)	1		00 NOT use <b>keeper</b>				Heal	th Car	o
17. F	ather's Name (	First, Middle	, Last)				-0 000 6	cpot		18. Mother's Nar	me (First, Middle			_
	larance			er						Margarez	t Spink		·	
	Informant's Na						19b. Mailir	ng Address (5			ural Route Numb	er, City or	Town, State, 2	Zip Code)
Sa	ndra K.	Havu	yman			1	518 L	aw Str	eet	Aberdee	en, Hary	land	21001	
	Method of Disp		۰۰۰		. 04-4-	20b. Plac	e of Dispo	sition (Name natory or oth	of er place	e)	Date	20c. Loc	eation - City or	Town, State
	1 🔀 Burial 2 I 4 🗌 Donation			emovai fron		Calve	oru M	.E. Ch	wc	h Cem. (	8/3/07	Aber	ideen.	Maryland
21.5	Signature of Fu	neral Service	License	200	0 m	an	22	2. Name and	TUE	ether lity his	tchell S	mith	Funera	L Home , MD 21078
23a.	Part1. Enter ti	ne disease, o	or contain	cottons that	caused th	ne death.					c or respiratory a			Approximate Interval Between
Imm	ediate Cause (	Final	of Office Offi	cause on	each line.	1/4	1.11	11.	1					Onset and Death
	ase or condition ulting in death)	П	a	Due to	(or as a	consequer	nce of):	m	_					
0		- 4141	h h											
if any	uentially list col y, leading to im se. Enter Unde se (Disease or	mediate	"	Due to	(or as a	consequer	ice of):						7.0	
man	se (Disease or initiated events Iting in death) L		c		(									
			ŧ	Due	(or as a t	consequer	ice oi):							
			d											
23b.	EMALE: Was decedent in the past 12 1 Yes 2	months?	2:		birth 2 nant at tir	pregnanc □Fetal de me of deat	eath 3	]Ectopic preç ] Other <i>(</i> s <i>pec</i>				2	3d. Date of del	ivery Day Year
	9 ☐ Unknown ii. Other signif	leant condit	ione con			not reculting	og in the u	adorlying cou	no divo	n in Bort I	230 Did 1	obacco us	o contributo to	the cause of death?
raiti	ii. Other sigilii		ions con	unduling to	Jean Dut	not resulti	ig iii tile di	idenying cau	se give	IIII Fait I.		Yes 2		
											24a. Was auto	psy	prior to	utopsy findings availat completion of cause o
											perfo	2 No	death? 1 ☐ Yes	
	Nas case references			loonital:					Lou		ath (Check only	one)		
	∏Yes 2∰			_	Inpatient		/Outpatien		Othe	4   Nursing F	lome 5 Resi			cify)
1	Againer of Deatl	5 Pendi		28a. Date (Mo	nth, Day	rear)	Bb. Time of Injury	M 280	: Injury Work	at ? ′es 2 ⊡No	28d. Describe	how injury	occurred	
3	Accident Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Contr	6 ☐ Could	not be nined	28e. Plac	e of injury ding, etc.	· At home (Specify)	e, farm, str	eet, factory, o	-	es Z No	28f. Location ( City or To			ural Route Number,
29a.	Certifier (Check only	1 Certifyi	ing Phys	ician: To the	e best of e	my knowle	edge, deatl	n occurred at	the tim	e, date and place	e, and due to the	cause(s)	and manner as	s stated. e to the cause(s)
00-	one)	-1		and ma	nner state	M.				number	1			
29b.	Signature and	title of gertific	er er		In.	An	111	290. [	License	1901	2	29a. Date	signed (Mont	n, ∪ay, Year)
		nun		14 /	n	000	IN	District A	119	2806		2	1110	//
30. N	Name and addr	ess of person	n who co	mpleted cau	is of dea	th (Item 23	3a) (Type	Print <	Soul	A Cul	se Al	14	16 1	1 7/275

3

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 200  $P^{M}$ O 8:55 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 40 Mary Alense Edgewater Sonol If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Days 1 □ M 2 X F Yrs. 220-07-7330 95 05/16/1912 Director Marvland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be not lfled at 1 TiYes 2 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 140 Maryland Avenue death v Funeral 21037 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 

Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drugstores C1erk Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it once, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Rawlings Sarah E. Hubbard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica F. Poirier/Daughter 134 Maryland Avenue, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) Lakemont Memorial Gardens 08/06/2007 Davidsonville, Maryland 4 ☐ Donation 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature de la Survice de la censee UM 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 years /Medical Due to (or as a olinsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line of denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2210 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

AUG 0 8 2007

29b. Signature and title of dertifier

31. Date filed (Month, Day, Year)

30. Name and address of

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

e Rd Sate 300 Annapols

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

Tay Chee GW Best GW

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Dolores Louisa POFFENBERGER /Medical 0 2007 21.50 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CENTER EDICAL DALISBURY 100mico If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Months Days Hours 220-26-5704 Director 75 March 12,1932 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shi dical Examiner must be notified Maryland Washington Director Hagerstown 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18913 Dover Drive 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Mamied 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No 3 ₩ Widowed 4 Divorced Specify: white traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) owner food and beverage 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file tment of Health and Mental H tant: If Item 27 Is marked out Be 18. Mother's Name (First, Middle, Maiden Surname) Ettore A. Vidoni Maddalena Mattioni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Poffenberger- daughter 1415 Hamilton Blvd., Hagerstown, Maryland other 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. August 2, 4 Donation 5 Dother (Specify) Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Violit Se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** complicating 18mo /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a nonsecute de la requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performe 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 1 hpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending (Month, Day Year) investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and tille of 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

JUL 3 1 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snyder

DHMH 17 Rev 1/2001

Registrar

7/27 10

		for State Registrar	State of	Marylan		artment of H		and M	lental H	ygiene Reg. No			
		Decedent's Name (First, Middle,	Last)						2. Date of D	Death			3. Time of Death
Physic /Medi			Li11	ian A.	Reisi	nger			Month July	21		Year 007	4:00p M
Exami		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, or	r Location o	of Death		4c	. County	of Death	<u> </u>
· (4)	A	Heart Fields Ass					deri				F1	reder	
Funeral Director			. Sex 1	7. Age (In yrs.	V	If Under 1 Year Months Days	If Under Hours	Min.		Day, Year,		Cour	
49.0		Usual Residence of Decedent		87					Jan. 3	30,19	20	Penns	sylvania
yland how at		10a. State 10b. County		10c. City	y, Town or Lo	ocation						1	0d. Inside City Limits
e Mau ta-fsl tified	cto	Maryland Frede	rick	Fre	derick								1 ☐ Yes 2 🖾 No
ith th	Director	10e. Street and Number				10f. Zip Code				10g. Cit	izen of	What Cour	ntry?
sath v s 23a nust		4260 Bear Den Ro			2 149	217						l Sta	
ter de item iner n	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deced Armed For 1 ☐ Yes	ces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori an, Mexicar	gin? (Spe n, Puerto	ecity Yes or N Rican, etc.)	10-		e - Americ ck, White,	
urs af al", or xam	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	9		1 ☐ Yes 2 🔀 No	Specify:				Specif	w. Whi	ite
72 hou latura ical E	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation	A = 4		16b. K	ind of B	usiness/Inc	
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hould d Me nark natic	2	Charles Wilhelm  19a. Informant's Name/Relationship			10b Maili	ng Address (Street a		7 Pfe		Oit		0	0.44
id 2 s Ith an 27 is r traur	1												(Code)
f Hea f Hea tem 2	- 18	Kevin S. Reising  20a. Method of Disposition	er/ Son	20b. P	lace of Dispo	opper Oak osition (Name of matory or other place		[	)ate	20c. L	D 21 ocation -	. / <u>98</u> · City or To	own, State
Page ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		late			<b>~</b> -0	JLY 3	O , 3007			3//11	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inductant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lie		Gal	2:	<ol><li>Name and Address</li></ol>	ss of Facilit	v	`	-	ngs	MILL	s,Maryland
a L D D		/ Yacqueline	7 Rai	botty.	$\begin{bmatrix} & 1 \\ 1 \end{bmatrix}$	tauffer F 621 Oposs	unera	ı⊥ Ho m Pi	me P. ke. Fr	A. ceder	ick.	MD 3	21702
		23 . Part1. Enter the disease, or co shock, or hear ailure. List or	ications that a	used the de the	n. Do not en	er the mode of dyin	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between
hysician		Immediate Cause (Final disease or condition				5cello			tn/				Onset and Death
/Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):		17.						
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nysic his ce I direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 3 DOA Othe	er: 4 □ Nu	rsing Ho	ne 5□Res	sidence	6 Oth	er (Specif	ASSISHED
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after after Direction by	Certification:	4 ☐ Homicide determine		g, etc. (Specif)		eet, factory, office		- 1	City or To	own, State	e)	er or Hura	l Route Number,
spira nours neral / filled		29a. Certifier CertifyIng	Physician: To the I	pest of my kno	wledge, deat	h occurred at the tim	ne, date an	d place,	and due to th	e cause(s	) and ma	anner as st	tated.
To the Tospilar of Attending Prysician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Ex	aminer: On the ba and mann	sis of examina	tion and/or in	vestigation, in my o	pinion, dea	th occurr	ed at the time	e, date an	d place,	and due to	the cause(s)
Within Comp	Me	29b. Signature and title of certifier		1		29c. License	e number			29d. Da	te signe	d (Month,	Day, Year)
		1 May 1	tiren x	1 54	ah	D5	164	13		7/2	23/	22	
2		30. Name and address of person wh	no completed cause	of death (Item	23a) (Type,	Print)				1	250	lani	tops mil
<i>J</i>		31. Date filed (Month, Day, Year)	54RA 30 PM	65 C	ture B	mas	5. Th	ons	on A	<u> </u>		2170	2
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

07-05631 Ma

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ateo L. Rios	State of Maryland / Departm 1- For State Certific	ent of Health and Mental Hyg cate of Death	Reg. No.
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		Date of Death  Month  Day  Year  O120 bro
edical Examiner	Mateo Leonardo Rios  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 23, 2007 01301118 4c. County of Death
	SB Interstate 495 S. of River Road	Potomac	Montgomery
Funeral Director	5. Social Security Number 225-41-5113 6. Sex 7. Age (In yrs. last bit 1 X M 2 F	rthday)   If Under 1 Year   If Under 24Hrs.   Months   Days   Hours   Min.   Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Bolivia
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
<b>*</b> .	Virginia Fairfax Falls	Church	1 Yes 2 XXNo
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 6443 Maplewood Drive	10f. Zip Code 22041	10g. Citizen of What Country? USA
or items 23	11. Marital Status 1 X Never Married 2 Married 2 Armed Forces?	13. Was Decedent of Hispanic Origin? ( Spe If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- tican, etc.) 14. Race - American Indian, Black, White, etc.
fter des I', or i	3 Widowed 4 Divorced of Yes 2 1 No	1X Yes 2 No specify:Boliv	
5 72 hours aftu natural" sal Examine leted by		<ul> <li>Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire</li> </ul>	ork done 16b. Kind of Business/Industry
-0036 I within 72 giene. her than " e Medical I		Student	Student
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "nati- injury or other traumatic event, the Medical Exa- To Be Completed	17. Father's Name (First, Middle, Last) Florian Miquel Rios Oropeza		First, Middle, Maiden Surname) Beatriz Gutierrez Claros
2121 ould be fi d Mental 3 s marked tic event,		9b. Mailing Address (Street and Number or Ru	ural Route Number, City or Town, State, Zip Code)
MD d 2 sho Ith and n 27 is numati	Florian M. Rios/ Father	6443 Maplewood Drive	, Falls Church, VA 22041  Date 20c. Location - City or Town, State
Ore, ges 1 an of Hea If iter ther tra	1 X Burial 2 Cremation 3 Removal from State crem	atory or other place)	y 27, 2007 Falls Church, VA
Baltimore, permit Pages I an Department of Hee Important: If ite	4 Donation 5 Other Specify: Uakwii 21. Signatur Funeral Service Licensee	<u> </u>	rly Community Funeral Care
Ba Dem Dep Inip	Mucy mo1453	6161 Leesburg Pike	, Falls Church, VA 22044
Physician Medical	23al Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or	Between Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):		
1	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ted Innsit	cause. Enter Underlying Cause (Disease or Injury that initiated by the disease or Injury that initiated by the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease of the		
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cords, P.O. Bo) aw requires that the death has been signed by the att 2 should be detached for		ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
s, P.O.  Jires that the signed by dobe detach			1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been signage 2 should be			autopsy prior to completion of cause of death?
tal Rection: The Jector, page		26.Place of Death (Check of	1 Yes 2 No 1 Yes 2 No only one)
Vital hysician this certi	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER	VOutpatient 3 DOA Other Nursin	g Home 5 Residence 6 Other: Scene
Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beautification. To Be Completed by Divisional Marian Confiference of the Completed by Divisional Marian Confidence of the Completed by Divisional Mar		b. Time of Injury 28c. Injury at Work?  121 hrs 1 Yes 2 ✓ No	28d. Describe how injury occurred Passenger auto fixed object collision
or Att or Att after de Directe I in by t	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) SB Interstate 495 S. of River Road, Potomac, MD
Divis  Proprietation A  124 hours after  Francial Directly filled in b		death occurred at the time, date and place, and	due to the cause(s) and manner as stated.
To the He within 24 To the Fr completed	one) 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 23, 2007
3	30. Name and address of person who completed cause of death (Item 23	la)	
	Tasha Greenberg MD. Assistant Medical Examine		O 21201
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sperk	

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Division or Vital Records, P.O. Box 68760,

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		For State Registrar		State	OI Waiyi		Certifica			wentai ny	Reg. No.	- 73 - 7 -	, ,	
Physici	ian	1. Decedent's Nam								2. Date of D Month	Day	/ Year	3. Tim	ne of Death
/Medic	cal	4a. Facility Name (	LAWREN		number)			ITH	or Location of Deatl	07	31	2007 County of Dea	144	49 M
Examir	ner			DDOCK CA				MBERI		1		LLEGANY	un	
Funeral		5. Social Security I		6. Sex 1 M 2 F	:	rs. last birth	Month	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth lay, Year)	9. Bii	thplace (Sta	ate or Foreign
Director		199-24-4 Usual Residence of		X 201	75	Yr	S.			Jul 23,	1932	2	Pa	
ryland rhow	_	10a. State	10b. County		10c.	City, Town	or Location							le City Limits
the Ma 28a-f s outified	ecto	MD  10e. Street and Nu		gany		L 111					40 0%			Yes <b>x</b> <sup>2</sup> □ No
3a or	Ö			oad, NE			101. 2	ip Code	21530		Tug. Citi	izen of What C	ountry?	
r death	Funeral Director	11. Marital Status	<u>Juliout i v</u>	12. Was D	ecedent Ever in Forces?	n U.S.	13. Was Dec	edent of F	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or N	0-	14. Race - Am Black, Whi		٦,
s after	by Fu	1 ☐ Never Mar 3 ☐ Widowed		ried 1 □ Ye If Yes.	s XIINo		1 ☐ Yes		Specify:			Consider		
2 hour atural ical Ex	ted k		15. Deceden	t's Education		16a. D	ecedent's Us	sual Occup	oation		16b. Ki	nd of Business	ACK Industry	
ithin 7 ne. nan "r	Completed	Elementary/Sec	ondary (0-12)	st grade complete College	e (1-4or 5+)			vork done use retire	during most of word)	rking				
filed w Hygie other ti		17. Father's Name	12 (First, Middle,	Last)		⊥carp	enter		18. Mother's Nan	ne (First, Middle		Surname)	<u>-</u>	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be		ood W.	*						Clapton	,			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N Mary Sr			wife	19b. N	Mailing Addre	ss (Street	and Number or Ru Road NE	ral Route Num Flint	ber, City o	r Town, State,	Zip Code) 1D 21	530
s 1 and f Health item 27 other tr		20a. Method of Dis	sposition		20	b. Place of D	Disposition (N	ame of	· · ·	Date		cation - City or		
Pages ment of t ant: If ite			Cremation 5 ☐ Other (S	3 □Removal fro Specify)	m State Sc		ciematory o uneral l			8/3/2007	Cr	esaptov	/n	MD
permit. Departi Importa any inj once.		21. Signature of F	neral Service	Licensee	///	,			i Funeral Hor		'			
		23a Part Enter	the disease, or	complications that	at caused the d	eath. Do not			inia Avenue:			21502	Annroxi	imate
Physician		Immediale Cause	(Final		n each line. CUTE IN				ng, such as cardiad		a1100t,		Onset a	mate Between and Death
/Medical Examiner		disease or condition resulting in death)	)II	a.	to (or as a cons			SINOC	TION				1 1	DAY
Examiner	ř	Sequentially list co	onditions,	b. Due	to for as a cons	sequence of								
uted	Examiner	Sequentially list concause. Enter Under Cause (Disease or that initiated event	erlying r injury		to gor do d com	ocupacinoc oij								
be executed cian and ourial-transii	Exa	resulting in death)	Last	c	to (or as a cons	sequence of)	i:					<del></del>		
icate be executed physician and s the burial-transit	dica			d										
eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant		outcome pf pre							23d. Date of de	livery	
e death he atte	Physician/Medica	in the past 12 1 ☐ Yes 2	2 months? □ No		e birth 2□F egnant at tìme o known		3 □Ectopic 5 □ Other (		y 			Month	Day	Year
requires that the death certificate een signed by the attending physi nould be detached for use as the I		9 ☐ Unknowr Part II. Other signi				resulting in th	ne underlying	cause giv	en in Part I.	23e, Did	tobacco u	se contribute t	n the cause	of death?
quires n signe ald be	d by	DIABE		ELITIS							Yes 2	-		Unknown
	Completed	ACUTE	RENAL	INSUFFIC	CIENCY					24a. Was		24b. Were a	utopsy findir	ngs available
<b>sician:</b> The law certificate has t irector, page 2 s	Com									auto perf 1□ Yes	ormed?	death? 1 ☐ Yes		or cause or
sician: certific irector,	o Be	25. Was case reference examiner?		Hospital:	<b>⊉</b> Inpatient 2	! ☐ ER/Outpa	atient 3□ [	Oth Oth	26. Place of Dea					
ng Phys ter this neral dii	$ \mathbf{F}_{ij} $	27. Manner of Dea	ıth	28a. Da	te of Injury onth, Day Year	28b. Tim	ne of	28c. Injur		ome 5 ☐ Res 28d. Describe			ecity)	
tendil leath. tor: A	catic	1 Accident 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investig	gation			М	1 🗆	Yes 2 □ No					
after of Direct of in by	Certification:	4 ☐ Homicide	determ	inod   208. F18	ice of injury - A ilding, etc. (Spe	e <i>cify)</i>	i, street, facto	огу, опісе			(Street and wn, State	d Number or R )	ural Route I	Vumber,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	ledical C	29a. Certifier (Check only	1 Certifyin	g Physician: To t	the best of my l	knowledge, o	death occurre	d at the ti	me, date and place	, and due to the	cause(s)	and manner a	s stated.	20(2)
thin 24	Medi	one) 29b. Signature and	<u> </u>	and m	anner stated.			9c. Licens		area at the time		e signed (Mon		
F 3 F 8		b olynature and					1	000	23280		A	a 1 2	007	,
А		30. Name and add	ress of person	who completed ca	use of death (I	tem 23a) (Ty	/pe, Print)		Λ	, .		<i>J/_</i>		
2		DR . SU 31. Date filed (Mon	TIM Day Voor	upta	Pegistrar's Sin	Ken-	+ HVE	NUE	Cum	berla	nd,	MD à	U500	2
Sta Registr		or. Date med (MOI	AUG 'U"	8 2007	Pegistrar's Sig	15.	Goods							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY Physician 2<sup>1</sup>8<sup>ay</sup> 200<sup>7</sup>9ar 4:30 P M Penny Michelle Brooks Simms /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 02/28/1961 Director 220-74-5600 46 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nd 2 should be filed within 72 hours after death with the Marylar lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show tranmatic event, the Medical Examiner must be notified at tranmatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20653 United States 20774 Hampshire Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: þ 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Budget Assistant U.S. Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Louis Marshall Brooks Rose Rebecca Dyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trainonce. 20774 Hampshire Place, Lexington Park, MD 20653 Deborah Newkirk/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/04/2007 | Park Hall, Maryland <del>Par</del>k Hall True Cem. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Oven Physician OVADIAN CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2: autopsy rmed ≥ 2 No certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) director Medical Certification: To Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) ò

Division or Vital Records, P.O. Box 68760, PENNY MICHELLE

Baltimore, Maryland 21215-0036

requires that the death certificate be executed Hospital or Attending Physician:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID FEDERLE MD HOLLYWOOD MARYLAND 20636

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 ☐ Homicide

(Check only

29a, Certifier

and manner stated.

AUG 0 1 2007



State

Registrar

within 24 hours a

To the Function

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

234198

29d. Date signed (Month, Day, Year)

7/29/01

			1 - For State Registrar	State of Ma	arylan		artment <i>tificate</i>			nd Me	, ,	iene	007	28:53
6	Physici /Medi	_	Decedent's Name (First, Middle, Last,	Lugarda	Faye	Spigl	er		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2	Date of Deal	, Day 200	)7 Year	3. Time of Death 4:05 A.M
	Examir		4a. Facility Name (If not institution, give  Washington Coun  5. Social Security Number 6. Se.	ty Hospit	e (In yrs. li	ast birthday)	If Under	Hag 1 Year	ersto	Death Wn	Date of Birth	4c. Co	unty of Death	g ton
	Director		215-14-1022	]M 2( <b>X</b> F	85	Yrs.	Months	Days	Hours	Min.	Month, Day,	1922	Cou	y land  10d. Inside City Limits
	th the Maryle or 28a-f ehor e notified at	Director	Md. Washingt		Too. Oily	Hager		Code	1.0		1	0g. Citizen	of What Cou	1 □ Yes 2 🔀 No
036	be filed within 72 hours after death with the Maryland stal Hygiene. sid other then "natural", or items 23a or 28a-f ehow event, I're Medical Estarinar must be notified at	by Funeral [	20601 Jefferson E  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		I	Was Deced f Yes, spec			in? (Specif Puerto Rid	y Yes or No- can, etc.)		Race - Amer Black, White	
Maryland 21215-0036	e filed within 72 hor al Hygiene. I other then "nature vent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+)	16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us Cle	k done du e retired) rk	uring most o				of Business/li	,
ryland	should be fill ind Mental Hi marked oth umatic even	To Be	17. Father's Name (First, Middle, Last)  William Hunter H  19a. Informant's Name/Relationship (Ty			19h Mailin	a Address		М	innie	e Smith Route Number	1		in Code)
e)	it. Pages 1 and 2 rtment of Health a rtant: If Item 27 Is njury or other tra		Harry R. Spigler (  20a. Method of Disposition  1 Burial 2 Coremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Eurogral Service Licens	(Husband)	ce	20601 ace of Dispo metery, cren thsbur	Jeff sition (Nam natory or ot	erso e of her place mato	n Blv y ry		gersto 28,	own ,Mc 20c. Locati Smith		42 Fown, State
	icate be executed to be partially special between the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial special control of the partial	dical Examiner	23a. Pand Enter the Gease, or compleshock, or heart unique. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		the death ne.	ence of):	er the mode	of dying	such as ca	ardiac or r		est,	1	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat te has been signed by the attending phy page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3 🗆	Ectopic pre					23d.	. Date of deliv Month	very Day Year
ords, P	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions cor	ntributing to death bu	ut not resu	lting in the ur	nderlying ca	use giver	n in Part I.		23e. Did tob	1_0		the cause of death? bably 4 □Unknown
		Completed									24a. Was an autops perform 1 ☐ Yes 2	V	4b. Were auto prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of 2 \( \text{No} \)
Division of Vit	문 등 등	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No F  27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1- Inpatie 28a. Date of Injur (Month, Day	v	ER/Outpatient 28b. Time of Injury		Other Sc. Injury	4 □ Nurs	sing Home	5 Reside	nce 6		ify)
É	i Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	. (Specify)	)					City or Town	, State)		al Route Number,
	To the Hospital within 24 hours a Vithin 24 hours a To the Funaral Completely filled	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of ner: On the basis of and manner sta	examinati	vledge, death on and/or inv	estigation,	it the time in my opi	nion, death	place, and occurred	at the time, da	ate and pla	d manner as sice, and due to gned (Month,	to the cause(s)
	N N N N N N N N N N N N N N N N N N N		Melih	mpleted square of the	agth /lto-	22a) /T '		DY	359	U	2.	7	27	07
H	-5 /	te	30. Name add address of person who co	27511 32. Registra	Je	Ffins	n	BLV	n g	SMI	MSBU	May 1	un a	21783
	Registr	ar	JUL 302	007		A. 1	month	,						

# Tai

05584 wan J. Sadler		St For State	oe or Print in ate of Maryla	and / Depar	tment of ificate of	Health	and	Menta	al Hyg	giene Reg. I		
Physician	1.	gistrar Decedent's Name (First, Midd Tai	<sub>e,Last)</sub> wan J. Sadl	er						Date of Death Month Da July 20, 200	ay Year	3. Time of Death 1633 hrs
		. Facility Name (if not institution Prince Georges Hosp	on, give street and nu	imber)		b. City, Tow Cheverl	у		,	(8)	4c. County of E	
Funeral Director		Social Security Number 578–94–3100	6. Sex 1 ★★M 2 F	7. Age (In yrs. la	st birthday) 1 Yrs.	Months Months	Days	If Under Hours	.Min.		16, 1976	oreign Washington, I).
w any	10	sual Residence of Decedent Da. State 10b. County aryland Prince	e George's	10c. City,	Town or Locati	on Temple	Hi11	s				10d. Inside City Limits 1 XXYes 2 No
th the Maryland 23a or 28a-f show any notified at once.	5 I	De. Street and Number  3606 Deslaurie				10f. Zip C		2074	8	10g.	Citizen of What U.S.A.	
death with the or items 23a amust be notifi	1 neral	-	Married Armed I	2XX No	If Y	s Decedent es, specify Yes 2	Cuban,	Mexican,	in? ( Spe Puerto F	ecify Yes or No- Rican, etc.)	14. Race - White, Specify:	
"natural",	≥ -	3 Widowed 4 Di 15. Decedent's Education (Sp Elementary/Secondary (0-12 12th grade			16a. Deceder during m		ccupation	on (Give k DO NOT i	use retire	ed)	Self-Emp	4 1 1 N 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. In tiem 27 is marked other than "naturinjury or other traumatic event, the Medical Exam.	e Completed	7. Father's Name (First, Middl					1	8.Mother	s Name	(First, Middle, Ma	aiden Surname)	
MD 2121 d 2 should be fi thth and Mental m 27 is marker aumatic event,	m I	9a. Informant's Name/Relation Brenda Smith (M	3606	Deslaur	iers	Carr	ber or R	ural Route Numb	er, City or Town	, State, Zip Code) 1 207/18 City or Town, State		
nore, Mages 1 and 2 art of Health t: If item 2		20a. Method of Disposition  1 X Burial 2 Cremati	on 3 Removal		Place of Dispo crematory or o	ther place)_	_		i			, Maryland
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	1	Donation 5 Other Signature of Funeral Service	ce Licensee or complications tha	)	//3	Name and A	- Pla	ce N	ĖE. V	ollins Fun Vashington	D.C. 20	0019
Physician 'edical .aminer	K	failure. List only one cau Immediate Cause (Final disea or condition resulting in death	se on each line. se a. Multiple (	Sunshot Wous a consequence	nds	The mode o	- uying,					Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	b. Due to (or a	s a consequence								
cuted nnd transit	Exam	(Disease or injury that initiate events resulting in death) Las	d	s a consequence	of):							
exe ian	sician/Medical	UNPENDED  IF FEMALE:		es, outcome of pre		etal death	3	Ectop	nic pregn	ancy	23d. Date of Month	delivery Day Year
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Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed after earth. The tall is after death certificate bas been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial—transled in by the funeral director, page 2 should be detached for use as the burial—trans	Completed									24a. Was autop perfo 1 <b>✓</b> Yes	rmed?	were autopsy infulning a validation prior to completion of cause of death?  Yes 2 No
ital Reichan: Ti ichan: Ti s certifica rector, pa	Be	25. Was case referred to merexaminer?	Hospital:	Inpatient 2	✓ ER/Outpation	ent 3 1	26.Plac	Other	_	only one)	Residence 6	Other:
n of Vi nding Phys th. r: After thii	ion: To		ending Jul 2	Date of Injury North, Day Year) 0, 2007	28b. Time 1539 hrs			Yes 2	_	Subject sho		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6	determined (Spe	Place of Injury - A cify) Apartme	ent					or Town, 2319 Shadys	State) side Avenue, S	
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical C	00 0 4/644	ng Physician: To the Examiner:On the ba	e best of my know asis of examinationer stated.	ledge, death oo n and/or invest	igation, in n	ny opini	on, death	bccarrec	nd due to the cau d at the time, date	Juliu piarer, and	er as stated. due to the cause(s) Ined (Month, Day, Year)
<b>A A B B B B B B B B B B</b>	Me	29b. Signature and title of ce		l Qa		29		nse numb C.M.E.	er		July 21, 2	
OR		30. Name and address of per Carol Allan, MD	Assistant Medi	cause of death (I cal Examiner	tem 23a) 111 Per	n Street	, Balti	more, N	AD 212	201		

State Registrar DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month Day Year)

			For	State of Maryla	and / Dep	artment of F	lealth and	Mental Hy	giene		
			State Registrar		Ce	rtificate of	Death		Reg. No.	- 1	)
	Dhusisi		1. Decedent's Name (First, Middle, La	ist)	.,			2. Date of De	eath Day	Year 3	3. Time of Death
Polis.	Physici /Medic		PAUL	R. SIMS					16, 200	)7 <u>1</u> 0	0:00 A M
	Examir	er	4a. Facility Name (If not institution, gi		" - 7 4		r Location of Deat		4c. County		~ ~ ~
			12000 Father 5. Social Security Number 6.		,#214 rs. last birthday,		mantown			rgomer	
i.	Funeral Director		-	1 □ M 2 □ F 7. Age (117 7)	Yrs.	Months Days	Hours Min.	(Month, Da	2,1936	Country)	e (State or Foreign Zland
			Usual Residence of Decedent			<u> </u>					
	rylan how		10a. State 10b. County		City, Town or L	ocation					Inside City Limits
	e Ma Sa-f s	cto	MD Mont	gomery		Germant	.own				1 Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V		,
	s 23a	Funeral Director	12000 Father	·			20874	2		.S.A.	Indian
	ter de item	ığ	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0.5.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	rto Rican, etc.)		k, White, etc.	
38	urs af	<u>م</u>	3   Widowed 4 □ Divorced	If Yes, Give	nk	1 ☐ Yes 2 ☐ Xio	Specify:		Specify	, Bla	ack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medikal Examiner must be notified at	Completed	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup	oation	autria a	16b. Kind of Bu	ısiness/Indust	try
215	thin 7	lg.	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done DO NOT use retire	d) -	-	_		
7	ed wi ygien er th t, the	S	12th			Self-E	mployed			ectric	city
nd E	be fill ntal H od oth even	Be	17. Father's Name (First, Middle, Las Vernon Hol				18. Mother's Na		, Maiden Surnam E. Sir	,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event, the Medical Examiner must be notified at once.	၉	-		105 Mail	in a Addunce (Cause	and Number of B				*** 00070
Na Na	d2sh tham 7 is n traun		19a. Informant's Name/Relationship Pauline Sims	(Daughter)		ing Address <i>(Street</i> L9 Snouf			-		2.007.2
	1 an Heal em 2		20a. Method of Disposition			osition (Name of ematory or other place		Date	20c. Location -		
Baltimore,	Pages nent of h	,	1X Burial 2 ☐ Cremation 3 [	JRemoval from State			,	06/07	The section	nd ale	MD
∄	artme ortan Injur		4 □ Donation 5 D Other (Spec		the second second second	7en Cem 22. Name and Addre		26/07   SNOWDEN	Frede		ME, P.A.
ñ	Depar Impor any Ir	4 4	tognan K.	Anmade	a . //	246 N. W					
	U (#36		23a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caused the de	eath. Do not en	iter the mode of dyir	ng, such as cardia	c or respiratory a	arrest,	Ap	proximate terval Between
	Physician		Immediate Caus (Final disease or condition			ery Dise				Or	nset and Death
1	/Medical		resulting in death)	Due to (or as a cons		sry Disc	ase				
E	Examiner		Sequentially list conditions.	b. Insulin	Deper	ndent Di	abetes	Mellit	us		
	pe iis	ine	ri any, leading to immediate	Due to (or as a cons							
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperli Due to (or as a cons		<u>lc</u>	<del></del>				
8760,	be ey ician buria	E E		Due to (or as a cons	equence on.						
387	ficate be executed physician and is the burial-transit	dical		<b>▲</b> d							
×	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg					23d Dat	te of delivery	
ă	death atter	cial	in the past 12 months?	1 □ Live birth 2 □ Fo 4 □ Pregnant at time o		□Ectopic pregnanc □ Other <i>(specify)</i> _	у		Mo		y Year
o	t the o	Physician/M	9 Unknown	9□Unknown							
S, T	s tha	by P	Part II. Other significant conditions	•	•	, ,	en in Part I.	23e. Did	tobacco use contr	ribute to the ca	ause of death?
ğ	w requires that been signed I should be det		Pulmonary	Vascular D	isease	9		1 🗆	Yes 2. № No	3 Probably	y 4 Unknown
000	law re as be	plet						24a. Was		Were autopsy	findings available etion of cause of
<u> </u>	The tate has page	Completed						perfe 1□ Yes	ormed?   c	death? 1 □ Yes 2 □	
Vital Records, P.O. Box	s <b>ician</b> : Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					ath (Check only			
7	hyslo this co	은	1 ☐ Yes 2 No		☐ ER/Outpatie		4 ☐ Nursing I		idence 6 Oth		
Ē	ing P		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Woi		28d. Describe	how injury occurr	ed	
S	ttend leath stor: the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I	4	home form of		Yes 2 ☐ No	OOf Lagation (	Chron to a med Misson	O! O.	a vita di visale au
Division or	after a	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	reet, factory, office			Street and Numb wn, State)	er or Hurai Ho	oute inumber,
_	spital ours neral filled		29a. Certifier 1 X CertifyIng P	hysician: To the best of my k	nowledge, dea	th occurred at the ti	me, date and plac	e, and due to the	cause(s) and ma	anner as state	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical		miner: On the basis of exam and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier	le le		29c. Licens	se number		29d. Date signed	d (Month, Day	/, Year)
	~				2 NU	O Doo	54843	mp	7-2	23 -0	7
4	5		30. Name and address of person who	completed cause of death (li	tem 23a) (Type						
			David Charles	MID ISC	1115 Sh	TOYE) VIDE	/ H K C . 事 4	STU- KC	CKVIII	e .FID	<b>ムいりつい</b>

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Day Year) 4 2007

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22, 3:40 a M **SCHENEMANN** 2007 ANN Julv /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's HCR Manor Care Largo Nursing Home Largo If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛱 F Director 220-28-5429 74 10-29-1932 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location 10b. County r than "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Prince George's Riverdale 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20737 6813 Riverdale Road, Apt. #L-7 U.S.A. Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Prince George's Cty. and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Library Clerical Aid 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 is marked oth any injury or other traumatic event 9DC8. 17. Father's Name (First, Middle, Last) Be Harry Frank Young Etta Wilson Boswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Galen R. Young Son 940 SE 10th Street, Lees Summit, MO 64081 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery | 07/26/2007 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyarrsville, MD 20781 Fart1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Generalized disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Deep venous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Pulmanany the attending physician and resulting in death) Last Due to (or as a consequence of) Completed by Physiclan/Medical low IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificete has page 2 2 No 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Yeer) Director: After the 27. Manne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide ŏ within 24 hours e To the Funerel L 1 (Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 7123107 20062116 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pain Drive Greenbelt MD Belle 31. Date-filed (Month, Day, Yeer) 32. Registrar's Signature. State 6 2007 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

# 07-05473

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

toya Snerri Sr	-	i- For State Registrar		rtificate of			Reg.	No.	3. Time of Death
Physicia edical Exami	411.7	Decedent's Name (First, Middle, LATOYA	-ast) SMITH				Month D July 17, 200	ay Year 7	0250 hrs
euicai Exami		4a. Facility Name (if not institution,		1	4b. City, Town, or	Location of Death	July 17, 200	4c. County of Dea	ath
		Southern Maryland Hos		]	Clinton			Prince Georg	
Funeral		5. Social Security Number 6	Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Yea		8. Date of Birth (	MM/DD/YYYY) 9. E	Birthplace (State or D. C.
Director		214-23-5603 Usual Residence of Decedent	M 2XF	23 Yrs	Months Day	/s Hours Min.	JUNE 15		WASH.,
i ow any		10a. State 10b. County D.C.		, Town or Locati HINGTON					10d. Inside City Limits  1 Yes 2 No
//aryland 28a-f show d at once.	횽	10e. Street and Number	WADI		10f. Zip Code		10g	. Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at ouce.		2800 JASPER RD.,	#202		20020			UNITED ST	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Merlal Hygies 27 is marked other than "matural", or items 23a or 28a-f she amatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 Marr	ried 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No			ispanic Origin? ( Sp an, Mexican, Puerto		14. Race - Am White, etc.	erican Indian, Black,
fter de I", or	딘	3 Widowed 4 Divor	ced If Yes, Give Year	1 🗌	Yes 2X N	o specify:		Specify: B	LACK
hours.a natural Examin	d b	15. Decedent's Education (Specif				ation (Give kind of ve. DO NOT use reti		6b. Kind of Busines	s/Industry
136 thin 72 h ie. than "in edical E	pleted	Elementary/Secondary (0-12)	College (1-4 or 5+) 2	adming th	loge of Working in	CASHIER		PRIVATE	
5-0036 Iled within 72 Hygiene. I other than the Medical	Comple	17. Father's Name (First, Middle, L	ast)	<u> </u>		18.Mother's Name	(First, Middle, Ma	iden Surname)	
21215 uld be file Mental H marked o	Be (	ROBERT L SMITH		70.550.00			OLBERT		
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other that natic event, the Med	1	19a. Informant's Name/Relationshi	p (Type, Print )	19b. Mailin	g Address (Stre			er, City or Town, Sta	
and 2 shoulealth and N		MARY SMITH/MO			DALLAS I			<ul> <li>MD . 20</li> <li>20c. Location - City</li> </ul>	
ore, ME ss 1 and 2 s of Health ar If item 27		20a. Method of Disposition  1 Burial 2 Cremation		crematory or ot		cinicio,	Date		
imore Pages 1 ment of H tant: If i		4 Donation 5 Other Spe	cify: CEI	DAR HIL	L CEMETE	ERY 7/	25/07	SUITLAN	D,MD
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		21. Signature of Funeral Servige L	non Day Vous	114	25 MARYI	ss of Facility CA	. N.E. W	ASHINGTON	, D.C. 20002
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	omplications that caused the teath	n. Do not enter t	the mode of dying	g, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Saddle Pulmonary Thro		lism				Death
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kecuted 1 and - transit	I Exa		d						
y ce exe cian a irial -	Medical	UNPENDED	AMENDED						
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tran	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pred		etal death 3	Ectopic pregna	ancy	23d. Date of deliv	very Day Year
Box 687 death certific the attending F	sician/	past 12 months?	4 Pregnant at time of d		ther (Specify)				
Bo; e deat the at ed for	Phys	1 Yes 2 No 9 V Unkr	9 OHRHOWH				02a Did tak	and use contribute	e to the cause of death?
ries that the d signed by the	by	Part II. Other significant condition	ons contributing to death but not	resulting in the	underlying cause	e given in Part I.			Probably 4 Unknown
ords, w require is been sig	Completed						24a. Was a		e autopsy findings available
COL law rathas b	힡						autops	ned? death	
Vital Recipysician: The lithis certificate I director, page	ខ	OC M		<del></del>	26 Pla	ce of Death (Check	1 Yes 2	No 1 ✓	Yes 2 No
ital ician: s certi	B	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	✓ FR/Outpatier		Other		Residence 6 O	ther:
of Vi ing Physi After this uneral dir	[유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of		ijury at Work?		ow injury occurred	-
on of onding Photh.  Ith.  After to the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of funeral of fu	Ęį	1 V Natural 5 Pendi	ng		1	Yes 2 No			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could	inot be 28e. Place of Injury - At I	home, farm, stre	eet, factory, office	e building, etc.	28f. Location (Si or Town, St		Rural Route Number, City
Lospital 4 hours funeral		4 Homicide deterr 29a. Certifier 1 Certifying Ph	vsician: To the best of my knowle	edge, death occi	urred at the time,	date and place, an	d due to the cause	e(s) and manner as	stated.
thin 2 the I	Medical	(Check only one) Medical Exam	iner:On the basis of examination and manner stated	and/or investig	ation, in my opini	on, death occurred	at the time, date a	nd place, and due t	o the cause(s)
T W I I	§	29b. Signature and title of certified	10 111		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
		X1//X	4/		0.0	C.M.E.		July 17, 2007	
1 (3)			who com, leted cause of death (Ite		nn Street. Ba	altimore, MD 2	1201		
	tate		32. Registrar's Signa						
Regi		44 44 13 34 13117	Been D. R.	100 mil					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Robert Lee Twigg

		1- For State Registrar		Ċe	rtificate	of Death			,	Peg No		V 3.1
Physicia	n/	Decedent's Name (First, Midd	le,Last)					2	Date of De			. Time of Death
Medical Examir	ıer	Robert Lee I	wigg						Month July 30, 2	Day Y 2007	ear	1320 hrs
		4a. Facility Name (if not institution 8243 Eastern Blvd	n, give street and nu	imber)		4b. City, Towr Essex	n, or Location	of Death			y of Death ore Count	ty
<b>Funeral</b>		5. Social Security Number	6. Sex	7. Age (In yrs.	ast birthday	) If Under 1	Year If Und	der 24Hrs.	8. Date of B	irth (MM/DD/YY)	(Y) 9. Birthp	lace (State or
Director		217-34-2003	1 X M 2 F	72		Yrs. Months	Days Hour	rs Min.	08/03	3/1934	Foreign Count	West <sup>Iry)</sup> Virginia
any	ŀ	Usual Residence of Decedent  10a. State  10b. County		10c. City	Town or Lo	ocation						Od. Inside City Limits
<b>≱</b> ,		Maryland Balti				,000						Yes 2 X No
Aaryland 28a-f show 1 at ouce.	윉	10e. Street and Number	rmore	Ess	ex	10f. Zip Coo	le		1	10g. Citizen of V		
th the Maryland 23a or 28a-f shu notified at once	Director	8243 Eastern B	1vd			21221			- 1			
with ms 23.		11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of	Hispanic Or	igin? ( Spec	ify Yes or N	United 0- 14. Rad		n Indian, Black,
death or iter	Funeral	1 Never Married 2 M	Armed Fo	orces?		If Yes, specify Cu	ıban, Mexicai	n, Puerto Ri	can, etc.)		ite, etc.	
s after ral",	à		orced If Yes, Give Yea or Dates:		1	Yes 2 X				Specify	White	2
hour natu		15. Decedent's Education (Spe- Elementary/Secondary (0-12)			16a. Dece durin	dent's Usual Occi g most of working	upation (Give	kind of wor Tuse retired	k done	16b. Kind of E	Business/Indu	ustry
5-0036 led within 72 Hygiene. other than '	Completed	7	College (1	-4 or 5+)	Dela	-1 1/1		2	= 0			
215-0036 be filed within 7 ntal Hygiene. -ked other than ent, the Medica	탉	17. Father's Name (First, Middle,	Last)		Dies	sel Mecha		er's Name (F	irst. Middle.	Autom Maiden Surnam		
21215-00 uld be filed wit Mental Hygien marked other c event, the Me	e l	David William	Twigg					en Wei			,	
hould I hould I is mar	္	19a. Informant's Name/Relations	nip (Type, Print )		19b. Ma	iling Address (S	treet and Nur	mber or Rur	al Route Nu	mber, City or To	wn, State, Zi	p Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examiner must be notified at once	_	Timothy L. Twig	gg/ Son	Loci	1169	6 Little	Crit	ter La	ine, L	incoln,	DE 19	960
imore, Pages I and ment of Healt tant: If item or other trau	ı	1 Burial 2 X Cremation	3 Removal fro			position (Name of other place)	cemetery,		ate	20c. Location	- City or To	wn, State
Baltimore, cernit. Pages I ar Department of Hee Important: If iter njury or other tr.	-	4 Donation 5 Other Sp	ecify:	Bri	nsfie	1d-Echol	s Cr.	08/02	/2007	Charlo	tte Ha	11, MD
Balt permit. Departi Import	П	21. Signature of Funeral Service	Type	>~	.   4	z. Name and Add	ress or Facilit	<sup>ty</sup> Brin	sfiel	d Funer	al Hom	ne. P.A.
Physician		Kyle S. Simons 23a. Part I. Enter the disease, or	complications that ca	used the death.	Do not ente	2955 Hol	<u>Lywood</u>	d Road	Leo	nardtown	n, MD	20650 Approximate Interval
/Medical	4	failure. List only one cause Immediate Cause (Final disease	on each line.			rotic card						Between Onset and Death
raminer	1	or condition resulting in death)	Due to (or as a	consequence of	): 	our cara	LOVASCU	iar uis	ease			544.
	_	Sequentially list conditions,	b									
	=	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.	consequence of	r):							
ransit		events resulting in death) Last	Due to (or as a	consequence of	):							
7 7 E		X UNPENDED	d.									
760, cate be cate be physicia	ledical	IF FEMALE:	#23a,PI	I,27,perM	E,G871	, 9/4/07 T	Γ					
	E  2	23b. Was decedent pregnant in the past 12 months?	1 Live bi	utcome of pregr	•	Fetal death	3 Ectopi	c pregnancy	,	23d. Date of Month	of delivery Day	Year
Box 687: e death certification the attending ed for use as t	SICE	1 Yes 2 No 9 Unki	noun	ant at time of dea	ath	Other (Specify)					,	
the ched	Physicial	Part II. Other significant condition	9 UNKNO		sculting in th	A undorlying caus	o civon in Pr	oet I	220 Did to	<u> </u>	-114-4-41-	
P.C	이 6	Diabetes mellitu		death but not re	aditing in th	e underlying caus	e giveri ili Fa	ait i.			_	cause of death? y 4 ✔ Unknown
require	Completed							1	24a. Was			sy findings available
e law e has l								_		rmed?		oletion of cause of
Division of Vital Records, to a Attending Physician: The law require and a birector: After this certificate has been sited in by the funeral director, page 2 should built and the funeral director.		25. Was case referred to medical					ace of Death	(Chook and	1 Yes	2 No 1	✓ Yes	2 No
Vital ysician: his certif director,	וֹ מֿ	examiner?  1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatie		Other <sub>4</sub>	Nursing H		Residence 6	Other: So	ana -
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ion tendin eath.		1X Natural 5 Pendi 2 Accident Invest		Day, rear)		1	Yes 2	No				
or At or At after d Direc	2			of Injury - At ho	me, farm, st	reet, factory, offic	e building, et	tc. 28f	Location (S	Street and Numb	er or Rural F	Route Number, City
Division ospital or Attent hours after death meral Director:	<u>.</u> ا	4 Homicide deterr	nined (Specify)					Ų	or Town, S	tate)		
Division  To the Hospital or Attent within 24 hours after death with 74 her Funeral Director: completely filled in by the	<u> </u>	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best niner:On the basis of	of my knowledg examination an	e, death oco	curred at the time,	date and pla	ace, and due	to the caus	e(s) and manne	r as stated.	1100(0)
To ron	2	29b. Signature and title of certifier	and manner sta	ated.			nse number		- anio, date	29d. Date sign		
		(8 , 1-	0				C.M.E.			July 31, 20		Day, rear)
	3	30. Name and address of person v	who completed cause	of death (Item	23a)	. L.,				L		
		Laron Locke MD. As	sistant Medical	Examiner	111 Per	nn Street, Bal	timore, M	D 21201				
Stat Registra		11. Date filed (Month, Day, Year)  AUG 0	2067	istrar's Signatur	e 4. A	mele						
DHMH 17 Rev 1/200	1				ORIGIN	AL.						

or Vital To the Hospital or Attending Physician: Division the Funeral Director: within 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCES MATTHEWS, 31. Date filed (Month, Day, Year) State 2 6 2007

(Check only one)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

Registrar

D47604

29d. Date signed (Month, Day, Year)

2007

DHMH 17 Rev 1/2001

Registrar

07-05682
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arcelle Teresa Tu	1- R	For State		of Maryland /		tificate of l		wenta	Re	g. No	,	3. Time of Death
Physician/ ledical Examine		. Decedent's Name (First, Marce	widdle,Last) L1e Ter	esa Turner					2. Date of Deat Month July 23, 20		Year	2301 hrs
calcul Examina		a. Facility Name (if not insi University Hospita		street and number)		46	. City, Town, or Lo Baltimore	ocation of E	Death	4c. 0	County of Death	
Funeral Director		. Social Security Number 212-24-4657	6. Sex	7. Age M 2XF	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Bir Min. 04/29/1		Foreig	thplace (State or Mary Land untry)
vlaryland 28a-f show any: <u>1 af once.</u>	1 N	Sual Residence of Decede  Oa. State 10b. Co  Aryland Prin				Town or Locatio	1					10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f sh tiffed at onc	1	0e. Street and Number 2205 Iverson St					10f. Zip Code	20748		•	en of What Cou USA	ntry?
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once TO Re Commission by Firmeral Director	-	1. Marital Status 1 Never Married 2 3 X Widowed 4	Married	12. Was Decedent I Armed Forces? 1 Yes 2	Ever in U.s X	If Ye		Mexican, P	? ( Specify Yes or No Puerto Rican, etc.)	,	4. Race - Amer White, etc. Specify: Whit	ican Indian, Black,
5-0036 ed within 72 hours after than "natural" the Medical Examine Commissed by	ՏԻ	15. Decedent's Education  Elementary/Secondary (12th	(Specify on	or Dates:		16a. Decedent' during mo	s Usual Occupation of working life. In the Operator	n (Give kir			nd of Business/	W
215-0036 be filed within 7 that Hygiene. rked other than ent, the Medica		17. Father's Name (First, M	iddle, Last)			F	•	8.Mother's	Name (First, Middle,	1		
215. be filed ental Hy ricked of vent, th		Victor Elmer Wa	then						Bernadette			a Zin Cada)
MD 21; nd 2 should be alth and Men in 27 is mar aumatic ever		19a. Informant's Name/Rel Paul A. Wathen/							er or Rural Route Nu e Park, Md.			e, Zip Code)
Baltimore, Noemit. Pages I and Department of Health Important: If item Sinjury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraumingury or other fraum		20a. Method of Disposition  1 X Burial 2 Creat  4 Dogation 5 Oth	_	Removal from Sta	1 /	Place of Disposit crematory or oth Olivet (	ion (Name of cemer place) emetery		Date 7/28/2007		ocation - City of nington, D	
Saltinermit. Departments mports	1	21. Si un fure of Funeral S		see					George P. Ka Dxon Hill, M			me
Physician 'Mulical	-1	23a/Part I. Enter the disea failure. List only one	cause on ha	Ications that caused ch line. Head Injuries	the death							Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final di or condition resulting in de		Due to (or as a conse	equence o	f):		1.10				
ed nsit	Illiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying ( Disease or injury that thus	e Cause ateu C	Due to (or as a conse	335							
cuted and transit	EX.	events resulting in death)	Last d.		-							
60,  Ite be executed  hysician and  bunial - transit	ledical	UNPENDED		AMENDED	no of proo					23d	. Date of delive	rv
5x 687 ath certifical attending plor use as the	Sician/N	IF FEMALE: 13b. Was decedent pregnated past 12 months?  1 Yes 2 ✓ No 9	_	23c. If yes, outcor  1 Live birth 4 Pregnant at		2 Fet	aldeath 3 [ er (Specify)	Ectopic	pregnancy	- 1	Month	Day Year
P.O. Be es that the de igned by the be detached if	2	Part II. Other significant of	conditions	-	n but not r	esulting in the u	nderlying cause g	iven in Par		_		o the cause of death?
of Vital Records, P.C. ing Physician: The law requires that After this certificate has been signed inneral director, page 2 should be deter	Completed					<u>.</u>			24a. Wa auto peri 1 🗸 Yes	psy ormed?	prior to death?	
tal R cian: T certific ector, p	Be	25. Was case referred to r examiner?		Hospital: 1 ✔ Inpatie		] =D/O 11'1		Othori	Check only one)  Nursing Home 5	Reside	nce 6 Oth	er:
n of Vi	의	1 Yes 2 N 27. Manner of Death 1 Natural 5	Pending	28a. Date of Inju (Month, Day) Jul 20, 2007	ıry	ER/Outpatient 28b. Time of It 1525 hrs	njury 28c. Injur	ry at Work?	28d. Describe	how inju		<u> </u>
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 6 Homicide	Investigati Could not determine	be 28e. Place of in			et, factory, office b	uilding, etc	or Town.	State)		Rural Route Number, Cit
Di the Hospital hin 24 hours a the Funeral upletely filled	Medical	29a. Certifier 1 Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification	ing Physic al Examine	ian: To the best of m	y knowled mination a	dge, death occur and/or investigat	red at the time, dation, in my opinion	ate and place , death occ	ce, and due to the ca curred at the time, dat	use(s) an e and pla	d manner as st ace, and due to	ated. the cause(s)
<b>~</b> .   '	Mec	29b. Signature and title of	certifier	and manner stated.			29c. Licens O.C.I				Date signed (A / 25, 2007	nonth, Day, Year)
20.		30. Name and address of Laron Locke MD		completed cause of tant Medical Ex	death (Iter aminer	n 23a) 111 Penn	Street, Baltin	nore, Mi	D 21201			
Sta		31. Date filed (Month Day		32. Registra						_		
Registr		OCMETTA		~	1	ORIGINA						

ORIGINAL

			1 - For State Registrar	State o	of Marylan		artment of F tificate of		nd Mental Hy	giene Reg. No	6.6.	25 62
- 1	No.		1. Decedent's Name (First, Middle, Last,						2. Date of De		. Van	3. Time of Death
1975	Physici /Medic		Robert Stanley Wal	ker					July	31		03:40 A M
	Examir		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Town, o	r Location of		4c.	County of Death	
*			Harford Memorial H	ospita	el		Havre	de Gr	ace	На	rhord	
	Funeral		Social Security Number     6. Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours		rth	9. Birth	nplace (State or Foreign
	Director		218-20-4250	M 2□F		77 Yrs.			June 05	, 19		rsylvania
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y. Town or Lo	cation					10d. Inside City Limits
	faryli sho	5										1 ☐ Yes 2 🛣 No
	the h	Director	Maryland Harford  10e. Street and Number		Ha	vre de	10f. Zip Code			10g Cit	izen of What Co	intni2
	ath with the Marylan 23a or 28a-f show ust be nutified in		221 Lapidum Rd.				·					and y:
	leath	era		12. Was Dec	edent Ever in U.	.S. 13. V	21078 Was Decedent of H	lispanic Origi	in? (Specify Yes or No	u.s.	A . 14. Race - Amer	ican Indian.
0	after des or iteme	Funerai	1 Never Married 2 Married	Armed Fo 1 ☐ Yes	orces? 2 🕦 No	1	Yes, specify Cub	an, Mexican,	Puerto Rican, etc.)		Black, White	, etc.
3	urs a al', o Even	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D			I□Yes 2⊠ No	Specify:			Specify: (')	rite
215-0036	within 72 hours after death with the Maryland ene. Than "natural", or iteme 23a or 28a-f show Ta Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usual Occup	ation	of working	16b. K	ind of Business/I	ndustry
Z	thin thin thin thin thin thin thin thin	pie	Elementary/Secondary (0-12)	College (	1-4or 5+)	life. L	DO NOT use retire	d)	or working			
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/land	tai H d oth	Be	17. Father's Name (First, Middle, Last)						s Name (First, Middle	, Maiden	Sumame)	
Z	shoutd nd Men marke umatic	2	James Earl Walker						hy Whyte			
Z Z	ges 1 and 2 should it of Health and Mer it Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Ty		4.41				or Rural Route Numb			
a) a)	t and tealth im 27	10 3	Cynthia W. Hutton 20a. Method of Disposition	(vaugn	-		り アルクソスの( sition (Name of	ence K	d, Towson,		yCand 21 ocation - City or 1	
<u>ס</u>	or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from	State	semetery, cren	natory or other plac	1				
Баппо	permit. Pages Department of Important: If i any injury or onca.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		K.A	. Ferr	is and Co	0. 0.	8/02/2007	Wes.	t Cheste	er, PA
o n	Depa Depa impo any i			300	0000		Zellman N	lithce	ll Smith F n St. Havr	uner	al Home	
7,7			23a, Part1, Enter the disease, or compl	cations that o	caused the death	h Do not ente	S. Wash	ungto	n St. Haur	e de	Grace,	MD 21078 Approximate
- 5/2 - 1			23a. Part I. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Finat	e cause on e	each line.	2142	010	-	A .			Interval Between Onset and Death
(	Physician /Medical		disease or condition resulting in death)	HIZ	or as a consequ	KKH	910	2	HOCK			30 MIN
	Examiner			FSA	PUAG	BA)	ULCE	3R	BLEE	DI	NG	
		je.	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consequ	uence of):	VCT CI	TO COMPANY IN	all and a supervision of the			
P.	cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause Disease or injury that initiated events		RADI	ATI	M	1	ophac	711	17	
5	e exe ien a urial-1		resulting in death) Last	Due to	(or as a consequ	uence of):	10	011	1CER			
g/00,	cate be physicie the bur	dicai		l		LW	44	CH	VCEN.			
^		Mec	IF FEMALE:			-						
Š O	death certif e attending od for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live b	tcome of pregna pirth 2 ☐ Fetal	l death 3	Ectopic pregnancy	,		4 :	23d. Date of deli-	very Day Year
5	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	nant at time of de own	eath 5∟	Other (specify)					,
7.	w requires thet the death certif been signed by the attending should be detached for use a:	P	Part II. Other significant conditions con	tributing to de	eath but not rest	ulting in the ur	iderlying cause giv	an in Part I.	23e. Did t	obacco u	use contribute to	the cause of death?
ָרָ בּ	uires I sign Id be	d by	DEEP V	EIN	To	1ROM	1 BOS	15		Yes 2		. /
5	w req beer shou	ompieted							24a. Was		Odb More aut	anny findings available
ב ב	he la s hes ge 2	Ę							auto		prior to o	opsy findings available omptetion of cause of
I I	n: T ificate or, pa	ပိ	25. Was case referred to medical						1 ☐ Yes	2 NO	1 🗆 Yes	2 □ No
5	sicia s cert irect	o B	examiner? _ 4	ospital:	Inpatient 2	EB/Outpation	Oth	05	of Death Check only			
5	y Phy ar this aral d		27. Manger of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	28c. Injur	y at	sing Home 5 Resi			ity)
	nding th.	tio	1 Natural 5 Pending 2 Accident Investigation	(Mon	th, Day Year)	Injury	Wor	k? Yes 2∐N	0	•	•	
2	Atte	Hice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace	of Injury - At ho	ome, farm, stre	eet, factory, office					ral Route Number,
5	safte safte ai Dir	Certification:	4 🖂 Holliigide	Duildi	ng, etc. <i>(Specit</i> )	y)			City or To	wn, State	)	
	To the Hospital of Attending Physician: The law requires that the within 124 hours after death: within 124 hours after death: To the Euneral Director: After this centificate hes been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier Certifying Physical Check only 2 Medical Examin	sician: To the	best of my kno	wledge, death	occurred at the tir	ne, date and	place, and due to the	cause(s)	and manner as	stated.
	the H in 24 the F iplete	edical	one)	and mani	ner stated.	uon and/or inv	estigation, in my o	pinion, death	occurred at the time,	date and	place, and due	to the cause(s)
<b>.</b>	To To	Σ	29b. Signature and little of certifier	10 :		$\cap$	29c. Licens	e number	<b>3</b>	29d. Dat	te signed (Mo) th	, Day, Year)
			2 7 3 tha	wh	7 11	الما	D 2	+011		7	131/2	200 /
	6		30. Name and ad s of person who co	mpleted caus	death (Item	1 23a) (Type, I	Print)	040	CADRAV	7	Q RE	AJR MA
ĝ.	J		ASKOLA K. 145	K-WIN	legistral's Signal	J20	WILL	che	CAPBAB	D	1 DE	
	Sta		ST. Date filed (Mortin, Day, 1941)	110	ogiatian a alguna	1004					110	WIT

Months

WILSON

10c. City. Town or Location

7. Age (In vrs. last birthday)

10a, State

**ISABELLA** 

5. Social Security Number

238 50 5411 Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

1 □ M XXXF

BON SECOURS HOSPITAL

10b. County

4b. City, Town, or Location of Death

BALTIMORE

Hours

If Under 1 Year If Under 24 Hrs.

Days

17,

1929

2. Date of Death

8. Date of Birth (Month, Day, Year)

10,

JULY

NOV.

**Funeral** 

Director

death with the Maryland Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5009 FRANKFORD AVENUE 21223 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes X2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Completed by Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) raumatic event, the Medical and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12TH permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic avena-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EDWARD JAMES FAISON MATTIE DORA McCALLOP 19a. Informant's Name/Relationship (Type, Print) BRENDA TOYER / DAUGHTER 6012 PARKLAND COURT #102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 07/21/2007 21. Signature of Funeral Service Licensee 23a. Part 1 anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC COLON CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ABDOMINAL ABSCESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consuguence off URINARY TRACT INFECTION Due to (or as a consequence of): Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed 24a. Was an autopsy performe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Tes **SX**(X/Vo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide 24 hours a \*\*XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the To the within ? To the 29c. License number 29b. Signature and title of certifier H4SICIAN D57543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMORE STREET P.SANDHU, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

10d. Inside City Limits XXYes 2 □ No

9. Birthplace (State or Foreign

NORTH CAROLINA

3. Time of Death

1:12A

UNITED STATES Race - American Indian, Black, White, etc.

2007

4c. County of Death

Specify: BLACK 16b. Kind of Business/Industry

PRIVATE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

FORESTVILLE, MD 20747 20c. Location - City or Town, State

CLINTON, MD

22 Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.

4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XX inknown

2**XX**Vo

24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 TYes

Day

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JULY 17, 2007

BALTIMORE, MD 21223

Registrar

		For State Registrar		State of	Marylan				ealth a	and M	lental Hyg	giene Reg. No.	200	1	
Di		1. Decedent's Name (First, Midd	ie, Last)								2. Date of Dea	ath Day	Ye	ar	3. Time of Death
Physicia /Medic		Hilda B. Wil	1iam	S							July	30,	2007		5:10 PM <sup>M</sup>
Examin	_	4a. Facility Name (If not institution	_				,		Location of				County of D		
		Harrison Sr		ng of	Snow H:	<u>i11</u>		Snow r 1 Year	Hill If Under		Dott of Bird		rcest		and /State of Foreign
Funeral Director		5. Social Security Number	6. Sex	M 2∏F	. Age (In yrs. 91	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Oct 26	y, Year)		Coun	ace (State or Foreign try) .and
		215-18-4701 Usual Residence of Decedent	l								000 20,	1 1 7 1	110	*1 y 1	diu
yland	. [	10a. State 10b. Count	,		10c. Cit	ty, Town or Lo	ocation							10	Od. Inside City Limits
Ba-f-	cto	MD We	orces	ster		Snow H	i11								1 ☐ Yes 2√ No
/ith th	Dire	10e. Street and Number 1702 East Gate	n Dan d	#51	Ω		10f. Zi	Code 2	1863			-	zen of Wha USA	t Coun	try?
interior e., Mart y tailing 2 12 13 13 13 13 13 13 13 13 13 13 13 13 13	Funeral Director			2. Was Deced		C 12	Was Door			ain? (Sa	poitu Vas ar Na		14. Race - A	meric	an Indian
ter de	S.	11. Marital Status  1 □ Never Married 2 □ Ma	-	Armed Ford	es?	.5.	If Yes, spe	cify Cuba	n, Mexicar	i, Puerto	ecify Yes or No Rican, etc.)		Black, V	Vhite, e	etc.
urs af	by	3 ☐ Widowed 4 ☒ Divorce		If Yes, Give Year or Dat	es:		1 🗌 Yes	2 <b>∏</b> No	Specify:				Specify:	whi	te
72 ho	Completed	15. Decede (Specify only high				16a. Dece	dent's Usu	al Occupa	ation during mos	t of work	una	16b. Ki	nd of Busin	ess/Ind	lustry
ithin it	nple	Elementary/Secondary (0-12)	JSI G/ILUU	College (1-	4or 5+)	life.	DO NOT I	se retired	0						
led w lygier her th		12	( ==+)	1		regi	stere	ed nu		orla Blam	e (First, Middle,		ealtho	care	9
be fi	Be	17. Father's Name (First, Middle Rodney Clevel		Sounde							Jones	Maluell	Jumame		
should be filed within and Mental Hygiene. I marked other than umatic event, the Mental Hygiene.	ဥ	19a. Informant's Name/Relation				19b. Maili	na Addres	s (Street a			al Route Numbe	er. City o	r Town. Sta	te. Zip	Code)
and 2 sho salth and n 27 is m		Doris Shockley					_				ow Hill				,
of Health		20a. Method of Disposition			1 /	Place of Dispo	sition (Na	me of			Date		cation - City		wn, State
mit. Pages partment of portant: if it y injury or o		1 ☐ Burial 2 ☐ Cremation 4 ※ Donation 5 <del>☐ Ot</del> per (		moval from S	tate						:				
permit. Page Department ( important: if any injury or once.		21. Signat irre Funaral rivice on a I d	Sicense	HA	irecto					oard 2120	655 W.	Bal	timor	e S	treet
		27a. Part1. Inter the disea h. c shock, of heart failure. Lis	r sumplic	ations that ca	used the deat		altim ter the mo					rrest,			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	t only on		LONAR	Y ATI	hero	SCIE	2005	is					Onset and Death
/Medical		resulting in death)	( a.		r as a consec	quence of):									
Examiner		Sequentially list conditions.	b.		N GES		HE	ART	FAI	Lun	C.				
be sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ł	Due to (o	r as a consec	quence of):									
xecut and	Examiner	that initiated events resulting in death) Last	c.	Due to (c	r as a consec	quence of):						-			
es that the death certificate be executed to the the ettending physicien and be detached for use as the burial-transit			l.												
ificate g phy as the	Physician/Medical		u.												
ath cert	W/W	IF FEMALE: 23b. Was decedent pregnant	23	ic. If yes, outc	ome of pregnath 2 ☐ Feta		∃Ectopic p	rognancy					23d. Date of		•
death death ne etter	sicia	in the past 12 months? 1 ☐ Yes 2 MNo			nt at time of c		Other (s						Month		Day Year
at the at the laby the stach	Ph.	9 Unknown	1								l so- Bid.				
requires that the sen signed by the hould be detached	þ	Part II. Other significant condit	ions cont	ributing to dea	ath but not res	sulting in the t	inderlying	cause giv	en in Part i	-	1 🗆 1				e cause of death?
law requires as been sign	eted						· ·								
	ompleted			·							24a. Was autor		24b. Wer prior deat	th'?	psy findings available inpletion of cause of
age 1 1	O										1 ☐ Yes	2 No		Yes	21 No
	o Be	25. Was case referred to medic examiner?  1 Yes 2 No		ospital:	patient 2	] ER/Outpatie	at 2 🗆 D	OA Oth		-	th <i>Check only c</i> ome 5 ☐ Resi		6 □Other /	Cnach	4)
arthis	[ <b>⊢</b> ]	27. Manner of Death	-	28a. Date or (Month		28b. Time o		28c. Injun		arsing m	28d. Describe			эрвспу	′′
ath. Afte	at lo	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Month	i, Day Year)	Injury	М		k? Yes 2 ☐	No					
I or Attending after death. Director: After lin by the fune	Certification:	3 Suicide 6 Could 4 Homicide deter	I not be mined	28e. Place o	of Injury - At h g, etc. (Speci	nome, farm, st	reet, facto	ry, office			28f. Location (. City or Tox			or Rura	l Route Number,
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral directors.	ledical Ce	(Check only 2 Medica	ing Phys I Examin	er: On the ba	sis of examina	owledge, deal	th occurre	d at the tin	ne, date ar	nd place,	and due to the	cause(s)	and manne	er as st	ated.
the hin 24 the P	Medi	one)		and mann	er stated.				e number				te signed (A		
To To		29b. Signature and title of care	1	MD			23		0621	72			1/200		/1/
		30. Name and address of perso	uho oc		of death /lt-	m 23a) /Tunn	Print)								
	l i	Sharad R	SA	TYAL	, MD	1604	MA	RKE	T ST.	. Po	compice	GT	Y ME	) 2	21851.
Sta	ite	31. Date filed (Month, Day, Yea	r)	32. Ag	gistrar's Sign	ature									
Registr	rar	RIIC O	7 200	17   🔼		K A	and!	0							

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar		artmen rtificat			and M		jiene leg. No.	7	)
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medi		Stanley Melvi	n Woodfork						Ju1y	19	2007	8:30P M
ı	Examir	ier	4a. Facility Name (If not institution, give s	•		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	
			704 Camelot Wa			1/1/-		Wash				rince	George's
П	Funeral		5. Social Security Number 6. Sex	IM 2 TE	٧	Months	1 Year Days	If Under :	Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign ntry)
	Director		Usual Residence of Decedent	80	) '13.					Dec. 25	, 192	6 Wa	sh., DC
	land • •		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						1	Od. Inside City Limits
	Many	ţō	Maryland Prince G	a a waa la			T.	77	1 .				1 TYPes 2 □ No
	r 28s	Director	10e. Street and Number	sorge s		10f. Zip		. Was	surns		0g. Citizen	of What Cour	ntry?
	h with		704 Camelot Way	v				207	744		Un	ited S	tatos
	ours after death with the Marylar rel', or Iteme 23a or 28a-f ehow Examiner must be notified at	Funeral		12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Deced	ent of His			cify Yes or No- Rican, etc.)	14. F	lace - Americ	an Indian,
٥	or Ite		1 Never Married 2 Married	1 Y Yes 2 No If Yes, Give		1∐ Yes :		Specify:	i, Pueno i	rican, etc.)	Spe	Black, White,	etc. rican
ğ	hours tural',	d by	3  Widowed 4 □ Divorced	Year or Dates:		103		эрвспу.			3pe	Am	erican
<u>7</u>	within 72 hours after death with the Maryland ane. than 'natural', or Iteme 23e or 28e-1 ehow he Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	kind of wo	rk done d	urina most	t of workii	ng	16b. Kind of	Business/In	dustry
7	Mithir	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us	,						
N	e filed il Hygie other	ပိ	12th 17. Father's Name (First, Middle, Last)		Ma	il Ro				(First, Middle,		Govern	ment
a	A 10 24	Be c	Sylvester R. Wo	oodfork				10. 1100110				•	_
Ξ	should nd Men marke umatic	၉	19a. Informant's Name/Relationship (Typ		19b Mailir	na Address	(Street a	nd Numbe		Ethel L			
Maryland 21215-0036	and 2 siealth an m 27 is		Sharon L. Reynolo	·			•			e, Temp			
_	as 1 and 2 should to 1 Health and Ment Item 27 is marked rother treumatic a		20a. Method of Disposition		Place of Dispo cemetery, crem			100				n - City or To	
ē	ages ant of it: if I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval motili State	emetery, cren				7/26	/2007			
saltimore,	artme orter Injur	. 3	21. Signature of Funeral Service License							ewart F	unara	Clinto	n, MD
ñ	permit. Pages 1 a Department of He Importent: if Item any Injury or othe		1 John T. S	II lastust						Rd., NE			20019
Ш			23a. Part1. Enter the disease, or complic shock, pi heart failure. List only on	cations that caused the dear	th. Do not ent							10, 20	Approximate
	Physician		Immediate Cause (Final										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	METASTA  Due to (or as a conseq	uence of):	PANI		4/10	<i>- C</i>	ANCER			
	Examiner		A CONTRACT OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE										
	D .=	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):								
	nd	Examin	that initiated events										
Š	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a conseq	luence of):								
Q/8	# × 6	Physician/Medical	d.										
٥ ×	leath certifica attending ph I for use as th	Me	IF FEMALE:	D- 16		7.50							
ž 2	death c e attended for us	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live birth 2 Feta	ıldeath 3∐	Ectopic pr						Date of delive Month	ory Day Year
_ o	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5∟	Other (sp.	ecify)						July 102.
7.	w requires that the de been signed by the should be detached		Part II. Other significant conditions conf	tributing to death but not res	utting in the ur	nderlying ca	ause aive	n in Part I		23e. Did tol	pacco use co	ontribute to th	ne cause of death?
ďs,	sign sign	d by		•		,				1 🗆 Y	/	•	ably 4 Dunknown
cora	v req been shou	Completed								04- 146-			
ě	The law ste has b bage 2 st	E D								24a. Was a autops perform	V /	prior to cor death?	psy findings available mpletion of cause of
									-		2 No		2 No
<b>\rightarrow</b>	ding Physician: n. After this certific funeral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:			! Other	-	7	Check only on	30.		
5	Phy rate	-	27. Manny of Death	,	ER/Outpatien 28b. Time of		A	4 LI NUI		ne 5 ∏ Reside 8d. Describe ho			v)
Sion	th. : After funer	\$	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	8c. Injury Work 1 ☐ Y	? es 2∐N			,,		
	Attend r death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, stre	eet, factory				8f. Location (St	reet and Nu	mber or Rura	I Route Number,
5	after after d in t	Certification;	4 Homicide determined	building, etc. (Specif	(y)					City or Town	n, State)		,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.		29a. Certifier 1 Certifying Physi	ici <b>an</b> : To the best of my kno	wledge, death	occurred a	at the time	e, date and	d place, a	nd due to the ca	ause(s) and	manner as st	ated.
	he He in 24 he Fu	edical	(Check only 2   Medical Examination)	er: On the basis of examina and manner stated.	ition and/or inv	estigation,	in my opi	inion, deat	h occurre	d at the time, d	ate and plac	e, and due to	the cause(s)
	or within	Σ	29b. Signature and title of certifier	4.0			License			2	9d. Date sig	ned (Month,	Day, Year)
	(2)		cunjauxanos	MD			016	619			hely.	25 8	2007
	000		30. Name and address of person who com	npleted cause of death (Iten	n 23a) (Type,	Print)		(C)	- 1	0	1		1.10 0.10
	0					ESSIO	WAL	PL.	Scufe	104	Lance	aver,	MU. 20 185
	Sta	_	31. Date filed (Month, Day, Year)  JUL 2 6 2007	32. Registrar's Signa	ature								
	Registr	ai 💮	HII Z h ZUU/ Z.	2	and a								

DHMH 17 Rev 1/2001

			Please T	ype or Print in I State of Marylar						egible.		
			1 - For State Registrar	olato of Marylar		ificate of		viornai i i	Reg. No.	le j.,		)
id.	División de		1. Decedent's Name (First, Middle, Last)		1.	1		2. Date of Do	eath Day	Year	3. Time of Death	_
	Physici /Medic		Sander			Jaine		July	23	200		
	Examin	ier	4a. Facility Name (If not institution, give s		_		r Location of Death	11.	4c. C	ounty of Deat	h	
197. A	Funeval		5. Social Security Number 6. Sex	kins Hospita		If Under 1 Year	-	8. Date of Bi	rth	9. Birt	hplace (State or Foreign	
	Funeral Director				63 Yrs.	Months Days	Hours Min.	Feb 29	ay, Year)	Co	untry) yland	
٠	p ,		Usual Residence of Decedent  10a. State  10b. County	100 0	ity, Town or Loc	etice					404 1-14-03-11-14-	_
	faryla shov ed at	ō	10a. State   10b. County   Maryland   Frederic			erick					10d. Inside City Limits  1 Yes 2 No	
	be filed within 72 hours after death with the Maryland ttal Hygiene.  to other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Directo	10e. Street and Number 160 G. Willowdale	Drive		10f. Zip Code	1702		10g. Citize	en of What Co	untry?	_
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. W	as Decedent of F	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or N	0- 14	4. Race - Ame		_
-0036	urs after o al", or iter Examiner	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cub. □ Yes 2⊠ No		to Rican, etc.)		Black, White Specify:	e, etc. white	
<u>-</u>	"natura	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	16a. Decede	ent's Usual Occup ind of work done	oation during most of wor d)	rking	16b. Kind	d of Business/	Industry	
7	e filed within 7 al Hygiene. I other than "r vent, the Med	ф	Elementary/Secondary (0-12)	College (1-4or 5+)			∽ speciali:		E	Educati	.on	
ם מ	e filed al Hygi other rent, t	BeC	17. Father's Name (First, Middle, Last)			· · · · · · · · · · · · · · · · · · ·	18. Mother's Nan	•		,		_
/lar	2 should be and Menta is marked raumatic ev	ToE	Albert Vernon Sh	nafer			Geor	gette L	inthio	cum		
, mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Ty, Robert Warner - so	,	19b. Mailing 140.	Address (Street 5 Key Pa	and Number or Rurkway, F	ural Route Numl redericl	oer, City or K, Mai	Town, State, 2 Cyland	<sup>Zip Code)</sup> 21702	
ore	ages 1 and of He It it it it it it it it it it it it it it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State R	Place of Disposi cemetery, cremi esthave	ition (Name of atory or other pla n Memori	ce) a1 7-27	Date -2007	ı	ation - City or erick,	Town, State Maryland	
altim	nit. Pa artmer ortant injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Septice License			Name and Addre	i	tauffer	Funei	cal How	- 	-
מ	permi Depar Impor any ir		Charow (Paul	De Cleu			umtown P					2
1	110000	1	23 . Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea		-					Approximate Interval Between	_
ı	Physician		Immediate Cause (Final disease or condition		- Card	irmyo14	th				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse							166	
	Examiner	_	Sequentially list conditions,	Myocard	ruence of:	Intereti	100		-		1990	_
	nsit	Examiner	Sequentially list conditions, if any leading to minimum cause. Enter Underlying Cause (Disease or injury								>20 years	
<b>5</b>	executed in and rial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):	9	1001/				)	_
2/00	ate be nysicia he buri	ical		i								
X 08/	ertifica ing ph e as t	Med	IF FEMALE:									
J. Box	ie death certificate be executed the attending physician and ned for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome pf pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3 🗆	Ectopic pregnanc Other (specify) _	у		23	3d. Date of del Month	ivery Day Year	
Z.	w requires that the de been signed by the should be detached		Part II. Other significant conditions con	ntributing to death but not re	sulting in the und	derlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?	_
Sp	quires n sign lld be	d by						1,50	Yes 2□	No 3□Pr	obably 4 □Unknown	
ecords	law rec as beer 2 shou	Completed						24a. Was		24b. Were au	itopsy findings available	
ב	The Is	mo mo						auto perf 1⊟ Yes	opsy ormed? 2 No	prior to death? 1 ☐ Yes	completion of cause of	
VITal	ı <b>ysician:</b> The lav Is certificate has director, page 2	BeC	25. Was case referred to medical examiner?				26. Place of Dea			12.00	3	_
	Physician: r this certific ral director,	2	1 ☐ Yes 2 NHo		ER/Outpatient		4 LI Nursing F	łome 5 ☐ Res			cify)	_
	ling P	jon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor M 1	ryat rk? ]Yes 2 ⊟ No	28d. Describe	how injury	occurred		
Vision	vttend death ctor: y the i	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At h	nome, farm, stre		Tes 2 INO	28f. Location	(Street and	Number or Ri	ural Route Number,	
2	tal or / s after al Dire ed in b	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)				wn, State)			
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	edical		sician: To the best of my kn ner: On the basis of examin and manner stated.								
	To th Withir To th COMP	Me	29b. Signature and title of certifier	$\cap$		29c. Licens	se number		29d. Date	signed (Mont	h, Day, Year)	_
)			fra (a)	in, Do		RES	5-000		Jul.	7 23	,2007	
-	0		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, P	rint)		4.4.4		7		
	Sta	ate.	I i a Lehrer  31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	street b	altmose	MD	212	-5 /		_
	Sta Registr		JUL 2 6 20	07	K do	asti s						

	1. Decedent's Name (First, Middle, Last)								2. Date of Death			3. Time of Death	
an	Ethel Ardene Wil			1son	on			Month July	28	Year 2007	2:40	Α	
cal ner	4a. Facility Name (If not institution	ion, give sti	reet and num			4b. City, Town,	or Location of	f Death	042)		County of Death	2.10	
e	St. Mary's Nur	-		ŕ							. Mary'	c	
	5. Social Security Number	6. Sex			last birthday)	Leonard If Under 1 Year		24 Hrs.	3. Date of Birt			lace (State o	or Fore
			M 217 F		Yrs.	Months Days Hours Min			(Month, Day, Year)		Coui	Country) `	
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	10a. State 10b. Count	tv		10c. Ci	ity, Town or Lo	ocation		-			1	0d. Inside Ci	tv Lim
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ct	Maryland St. M	lary's	5	L€	eonardt								-A
Director	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?				
	44380 Red Tail Hawk Lane					20650				United States			
Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?			J.S. 13.						No- 14. Race - American Indian, Black, White, etc.			
로	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give												
2	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				1 ☐ Yes 2 🔀 No	Specify:			Specify: White				
2	15. Decede	ent's Educa	ation		16a. Dece	dent's Usual Occu	pation			16b. Kin	d of Business/In	dustry	
3	(Specify only highest grade completed)			life.	(Give kind of work done during most of working life. DO NOT use retired)				I '				
Completed	Elementary/Secondary (0-12) College		College (1-	Secre		etarv			τ		U.S. Government		
	17. Father's Name (First, Middle	le. Last)			,	- car	18. Mother	r's Name	First, Middle,	Maiden S	Surname)		
8	Leo Carl Drone							,	lia Ca		•		
٥١					1		1						
	19a. Informant's Name/Relation	nsnip ( <i>Type</i>	e. Print)		-	ing Address (Stree							
	Marsha A. Dysc	on/ Da	aughter			Red Tai				nardt	town, MD	20650	)
	20a. Method of Disposition	۵۵۵		20b.	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Da	te	20c. Loc	ation - City or To	own, State	
	1  Burial 2  Cremation 4  Donation 5  Other (		moval from S	tate		Veteran	1	าย/กว	/2007	Chal	tanham	Marsil	and
	21. Signature of Functal Service			) flat	y Land	2. Name and Addr	ess of Facility	/ Danda	72007	CHEL	cennam,	Maryr	anc
	1/1/1/1/1/	19		Tan Mi	00052.2	2055 11-1	7 1	DITI	istrero	Fun	eral Ho	ne, r.	Α.
13	Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the rode of dying, such as card, c or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between												
	CO. D. M. E.A. G. Press	C.C.					197			10.000			
	23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the complete on the comple	ations that ca cause on ea	used the dea ch line.	th. Do not en	ter the ode of dy	ring, such as o	cardiac or	respiratory ar	rest,		Approximat Interval Bet	ween
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State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No.								961.5		
		Registrar  1. Decedent's Name (First, Middle, L	Last)		Timouto or	Douin	2. Date of De	Et la	L F	3. Time of Death		
	ician	Raymond Olive		an			Month	Day	Year	11.20 aM		
	dical niner	4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town, o	or Location of	July 20 Death		nty of Death	11:30		
Funeral Director	ıııııcı	Holy Cross Reha		Conton	Daniel an an				Manaka			
	al		Sex 7. Age 7	n yrs. last birthday)	Burtonst If Under 1 Year Months Days	If Under 24		th Vear	Mont.go 9. Birthp Cour	lace (State or Foreign		
		577-22-3443	1 <sup>M</sup> M 2□F 9	6 Yrs.	Months Days	Hours	July 7	1911		nington, D		
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aryla shov										1 ☐ Yes 2 ☐ XNo		
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with a or		1910 Blackbriar Street			20903				JSA	id y ?		
If it is in the Maryland filed within 72 hours after death with the Maryland Hygiene.  Hygiene. Wher than "natural", or Items 23a or 28a-f show mit, the Medical Examiner must be notified at mit, the Medical Examiner must be notified at	Funeral Director	11. Marital Status					n? (Specify Yes or No		14. Race - American Indian,			
fter d r iten iner	H E	1 ☐ Never Married 2 Ă Married	Armed Forces?  1 N Yes 2 No				n? (Specify Yes or No Puerto Rican, etc.)		Black, White,			
urs a urs a Exarr	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☒ No	Specify:		Spe	e <sup>cify:</sup> White	•		
72 ho 72 ho lical I	Completed	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occu	pation	of working		f Business/In			
thin the and the	9	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	or working					
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2 should be and Mental is marked or aumatic eve	å	17. Father's Name ( <i>First, Middle, La</i>	st)			18. Mother's	s Name (First, Middle	, Maiden Suri	faiden Surname)			
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T and Health em 27 ther tr	V.	Margaret E. Wats		19: 20b. Place of Dispo	10 Blackh	riar S	treet, Sil		oring, on - City or To			
Pages 1 nent of H int: If iter	1	1 Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre Fort Line	matory or other pla	' i U	uly 25,	200. Escali	on only or re	mi, otate		
it. Puritme	O/	4 ☐ Donation 5 ☐ Other (Special Service Lice)	5.1,97				2007	Brenty	ood, I	Maryland		
permit. Departi	ouce.	1 (100)	a Cale				ns Funeral					
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplic tions that caused the				lvd, W, Si ardiac or respiratory a		pring,	Approximate		
Physicis		Immediate Cause (Final	ly one cause on each line.							Interval Between Onset and Death		
Physicia /Medic	_	disease or condition resulting in death)	a. Congesti Due to (or as a co	ve Heart	Failure	_			-	1 Month		
Examin	er			clerotic	Heart Di	50350				7 Years		
HOME!	je je	Sequentially list conditions, tary, cause Enter Underlying Cause (Disease or injury	Due to lor as a re		nearc bi	sease				/ lears		
cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c.									
be execian ar	Ä	resulting in death) Last Due to (or as a consequence of):										
icate be executed physician and sthe burial-transit	dical	•	d									
e as t	Mec	IF FEMALE:						- 1				
ath of trend trend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐	23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)  9 □ Unknown						23d. Date of delivery  Month Day Year		
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown								iii bay roa		
hat the deby detac			s contributing to death but n	ot resulting in the u	inderlying cause gir	ven in Part I	23e. Did t	obacco use c	ontribute to t	ne cause of death?		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Ş							]Yes 2No 3Probably 4Unknown				
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To the To the To the To the Comp	×	29b. Signature and title of certifier	71	A	29c. Licens				gned (Month,			
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10+1		30. Name and address verson wh	o completed cause of eath									
		George Sengsta	ck. M.D. 39:	29 Ferrar	a Drive.	Wheat	on, MD 209	06				

State Registrar

31. Date filed (Month, Day, Year)

JUL 24 2007

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2007 ALBERT R. WILLIAMS 21 9:15 A ™ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 22905 DAVIS MILL ROAD GERMANTOWN MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) Virginia Days Hours Months 1**X**M 2□F 226-28-0063 80 Yrs. 30 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Germantown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20876 22905 Davis Mill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy M. Spencer Williams Lewis Η. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22905 Davis Mill Road, Germantown, Md. Dorothy L. Williams / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/07 Frederick, Md. Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home Laytonsville, Md. 20882 Muriel H. Barber P. O. Box 5038, muru Barker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 7 years Immediate Cause (Final disease or condition resulting in death) Prostate Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2MNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r 28a-f show notified at

permit. Pages 1 and 2 shours as more Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once.

Baltimore, Maryland 21215-0036

Directo

with the Maryland

The law requires that the death certificate be executed

Hospital or Attending Physician:

0

Division or Vital Records, P.O. Box 68760,

Examine physician and s the burial-trans Physician/Medical as the attending use for detached ģ signed 2 Completed peen within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be ဥ Certification:

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗲 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) and manner stated 29b. Signature and title of dertifie

6 Could not be determined

1 🛮 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number D 29675 29d. Date signed (Month, Day, Year) July 23, 2007

Ralph V. Boccia, M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ralph V. Boccia, M. D. 6420 Rockledge Drive, #4100, Bethesda, Md.

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 2 4 2007 32. Registrar's Signature

Certificate of Death

4b. City. Town, or Location of Death

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3928 Calawasse Road, Edgewater, Maryland 20c. Location - City or Town, Stale 07/27/2007 Suitland, Maryland 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death pulmanarydise 23d. Date of delivery Year Month Dav 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) M Takoma Park, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 Washington Adventist Hospital, 7600 Carroll Ave., MD 32. Registrar's Signature

within 24 hours a To the Funaral I

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

6 2007

For State Registre

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Aradina Minerva White

4a. Facility Name (If not institution, give street and number)

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

Month

Ju1y

23

3. Time of Death Р. м

6:10 2007

4c. County of Death

Montgomery

 Birthplace (State or Foreign Country) Virginia

> 10d. Inside City Limits 1X Yes 2 □ No

10g. Citizen of What Country?

USA 14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry Kiplinger Publishing Company

18. Mother's Name (First, Middle, Maiden Sumame,

07-05804 Patrick John Vo

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

atrick John Yox	State of Maryland / Departm 1- For State Certific	eate of Death	Reg. No.	Shirly Servi
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examine	144		Month Day July 29, 2007	0/151115
	<ol> <li>Facility Name (if not institution, give street and number)</li> <li>Unit #06 Cell #18</li> </ol>	4b. City, Town, or Location of Death Princess Anne		c. County of Death  Somerset
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth (MM.	/DD/YYYY) 9. Birthplace (State or Foreign
Director	220-06-7303 1 M 2 F 33		Oct 24 1	973 Country MD
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with the Maryland ns 23a or 28a-f sho be notified at once.	10e. Street and Number 528 Bachman Valley Road	21158		USA
death with the Maryland or items 23a or 28a-f shamust be notified at once Tuneral Director		13. Was Decedent of Hispanic Origin? ( Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian; Black, White, etc.
		1 Yes 2 X No specify:		Specify: White
hours after natural", c Examiner 1	15 December 16 Education (Specificantly high set grade completed) 1160	Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retin		Kind of Business/Industry
71 3 - 1 7	Elementary/Secondary (0-12) College (1-4 or 5+)	Carpenter	,	Self Employed
21215-0036 21215-0036 suld be filed within 7 Mental Hygiene marked other than c event, the Medica	12 17. Father's Name (First, Middle, Last)		(First, Middle, Maider	
<b>—</b> □ □ □ □ o	Lanny Wayne Yox	-	lizabeth S	
Sho and and in ati	19a. Informant's Name/Relationship (Type, Print)  Mary Elizabeth Yox/Mother	9b. Mailing Address (Street and Number or F 528 Bachman Valley Ro		
ore, MD es 1 and 2 sho of Health and If item 27 is her fraumati		of Disposition (Name of cemetery, atory or other place)	0372007 20c.	. Location - City or Town, State
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Baltimo permit. Page Department of Important: injury or oth	21. S. natur of Fun Service Licensee	22. Name and Address of Facility Pritts Funeral Hor	ne and Cha	pel, P.A.
Physician	23a. Part I, Enter the disease, or complications that caused the death. Do failfure. List only one cause on each line.	1 412 Washington Roand enter the mode of dying, such as cardiac o	r respiratory arrest, sh	
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Heroin intoxication  Due to (or as a consequence of):	1		Death
	Sequentially list conditions,			
iner	if any, leading to immediate cause. Enter Ur daming Cause C.			
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Division of Vital Records, spital or Attending Physician: The law require normal Director: After this certificate has been sinfilled in by the funeral director, page 2 should be certification: To Re Completed	3 Suicide 6 X Could not be determined (Specify) state faci	farm, street, factory, office building, etc.		and Number or Rural Route Number, City Anne MD rection Institute Princes
hou hou		leath occurred at the time, date and place, and	due to the cause(s) a	and manner as stated.
To the Howithin 24 P. To the Funcompletely	one) 2 Medical Examiner: On the basis of examination and/o and manner stated.  29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)
	Carol Haroni	O.C.M.E.		ly 30, 2007
	30. Name and address of person who completed cause of death (Item 23a	1) 1 Donn Street Beltimers MD 2420	L	
Stat	Loo of the de Oissette	1 Penn Street, Baltimore, MD 2120	/1	
Registra		Speck		
DHMH 17 Rev 1/200	0	RIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#8.PerFHPGC8-3-07cr Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 1314AM JULY THOMAS YOUNG 22 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S If Under 24 Hrs. 8. Date of Birth (Month, Day, Young) 9. Birthplace (State or Foreign Country)
WASH., D.C. Social Security Number 7. Age (In vrs. last birthday Funeral . 1939 Days Months **1** ■ M 2 □ F 68 577-52-8694 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ä 1 Yes 2 No notified Director MD PRINCE GEORGE'S FT. WASHINGTON 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or must be 1240 PALMER RD 20744 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 14. Race - American Indian 11. Marital Status Black, White, etc. r than "natural", or iten the Medical Examiner 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) 3altimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DELIVERY 1 and 2 should be filed wi Health and Mental Hygien om 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT YOUNG MARIE M. MAYRANT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any Injury or other trac JUANITA YOUNG/ WIFE 6413 61st Pl., RIVERDALE, MD. 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □Removal from State MT. OLIVET CEMETERY WASHINGTON, D.C. 4 □ Donation 5 □ Other (Specify) 20002 22. Name and Address of Facility 21. Signature of Funeral Service Licensee - Dulle CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., 23a. Part1. Enter the dise 160 or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) In Tracevebral Hemornhage **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 I Inknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à pertension 2 No 3 Probably 4 donknown 1 TYes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No has page 2 : autopsy performed? Yes 2 No certificate ! 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death. uneral Director; A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

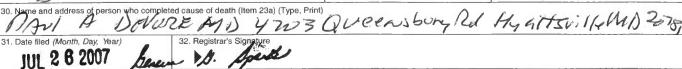
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated.

within 2

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



0135

			For State Registrar		State of Ma	aryıan		artment of r ertificate of		-	Gleri Reg. N		521/5
			Decedent's Name	(First, Middle, La	st)					2. Date of De		ay Year	3. Time of Death
	Physicia	-	SIDNEY M	. ZALEVSI	CΥ					Month AUGUST	3, <sup>Da</sup>		3:30 A M
	/Medic				e street and number)			4b. City, Town, o	r Location of Death	1	40	c. County of Death	
			SUBURBAN	HOSPITAI	_			BETHESDA			M	ONTGOMERY	
	Funeral		5. Social Security No		Sex 7. Ago	e (In yrs. 1	last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year	r) Coui	place (State or Foreign ntry)
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	and w		Usual Residence of 10a. State	10b. County	-	10c. City	y, Town or L	ocation			<u> </u>	1	10d. Inside City Limits
	f sho	5	MD	MONTECOME	-D37	СТТ	VER S	DDTMC					1X Yes 2 □ No
	the 1 28a- notifi	Director	MD 10e. Street and Nun	MONTGOME	EKI	SIL	VER 3	10f. Zip Code			10g. C	itizen of What Cour	ntry?
	aa or		702 LOWAN		₹.			20901			USA		
	ns 2	Funeral	11. Marital Status		12. Was Decedent I	Ever in U.	S. 13	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No	)-	14. Race - Americ	
(0	or ite		1 Never Marri	ed 2 Mamied	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	No		1 ☐ Yes 2 ☑ No		o nican, etc.)		Black, White,	HITE
ğ	ral", c	ğ	3 XWidowed	4 Divorced	Year or Dates:	WWII		1 1 1 e 3 2 2 2 2 1 NO	ореслу.			opeany.	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show with the Medical Examiner must be notified at	Completed	(Spec	15. Decedent's E			16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of work	king	16b. l	Kind of Business/In	dustry
2	ithin ne. han '	d m	Elementary/Secon	ndary (0-12)	College (1-4or 5	+)			a)		DE	TAIL	
'n	filed v Hygie ther t		17. Father's Name (	First Middle Last	5+		PHARM	ACISI	18. Mother's Nam	ne (First, Middle			
and	ed of	Be	HARRY ZAI		,				 PAULINE H	RIEDLAN	DER		
2	2 should be and Mental is marked or raumatic ev	ျ	19a. Informant's Na		Type. Print)		19b. Mai	ing Address (Street					Code)
<u>≅</u>	and 2 s ealth ar n 27 is ser trau		HARRIET (				1930	STONY HI	LL ROAD,	BOULDER	t, C	OLORADO	80305
ē,	- I - +		20a. Method of Disp	osition		20b. P		osition (Name of ematory or other pla		Date		Location - City or To	own, State
Baltimore,	Pages nent of I ant: If its any or o			☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State			NON CEMET		5/2007	ADE	LPHI, MAR	RYLAND
alti	- 主管管		21. Signature of Fu	neral Service Lice	nsee	-1	F	22. Name and Addre	ess of Facility	AT. DTREC	TTO	N. TNC.	
m	permi Depar Impor any Ir		Dona	ld. C.	Stattle	ny	2-11	091 ROCKV	TLLE PIKE	i, KOCKV	LLL	E, MARYLA	AND 20852
П			23a. Part1. Enter the shock, or hear	ne disease, or com rt failure. List only	plications that caused one cause on each lir	the death	h. Do not e	nter the mode of dyli	ng, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
>	Physician		Immediate Cause ( disease or condition	Final	severe i								Oliset and Death
1	/Medical		resulting in death)		Due to (or as	a conseq	uence of):						
	Examiner	_	Sequentially list cor	nditions,				RY FAILUR	E				
10	ed sit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	mediate rlying injury	Due to (or as								
7	and and II-trar	xan	that initiated events resulting in death) L		c. CARDIAC  Due to (or as								
68760,	ificate be executed g physician and as the burial-transit			Į	HYPOTENS	SION							
687	ificate g phy: as the	edical											
Вох	anding use	N/u	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome 1□Live birth			□Ectopic pregnanc	v			23d. Date of deliv	
m	death e atte	icia	in the past 12 1 ☐ Yes 2 ☐		4□Pregnant at			Other (specify)	у			Month	Day Year
Division or Vital Records, P.O.	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	Physician/M	9 ☐ Unknown						24	20 - 514	1		be a superior of death?
ŝ	es th	Ď	Part II. Other signif	icant conditions	contributing to death be	ut not resi	ulting in the	underlying cause giv	ven in Part I.			use contribute to t	bably 4 🛣 Unknown
ord	requii	Completed											
ec	has b	ple								24a. Was		prior to co	opsy findings available empletion of cause of
E	: The	S								1□ Yes	2 <b>½</b> N		2□ No
Ĭ.	Iclan certifi ector	Be	25. Was case reference examiner?		Hospital:			Oth	26. Place of Dea				
0	Phys this ral dir	. To	1 ☐ Yes 2 ☑ 27. Manner of Deat		28a. Date of Inju		ER/Outpation 28b. Time	ant 3 DOA	4 LI Nursing H	ome 5 ☐ Resi 28d. Describe		6 ☐Other (Speci	(y)
on	ding h. After funei	ion	1 🕅 Natural	5 Pending investigatio	(Month, Da	y Year)	Injury	Wo	rk? ]Yes 2 □ No		,	,	
<u>is</u>	Attending Physician: r death. ector: After this certifics by the funeral director, p	fical	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	e 28e. Place of init	ury - At ho	me, farm, s	treet, factory, office		28f. Location (	Street	and Number or Rur	al Route Number,
ă	al or al al or al Dire	Certification:	4 Homicide		building, et	c. (Specii	у)			City or To	WII, Ola		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only	1∑ Certifying Pi	hysician: To the best miner: On the basis o	of my kno	wledge, dea	ath occurred at the ti	ime, date and place	e, and due to the	cause	(s) and manner as	stated. to the cause(s)
	the H iin 24 the F	ledical	one) Ac		and manner sta								
	Veit To	Z	29b. Signature and	title of certifie				29c. Licens				3107	, vay, rear)
)			1/19	wyw					65182		01	110	
	25				zennz, 860				OAD, BETH	HESDA. M	IARY	LAND 208	314
	Sta	te	31. Date filed (Mon.	th, Day, Year)	3. Registr	ar's Signa	ature	all's					
	Registr		Al	JG 0 8 20	Registr 107	, ,0	140						

07-05941 John Adams

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			ficate of Death		g. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	1	3. Time of Death
Medical Exami	ner	JOHN H. ADAMS JR.  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	Month July 31, 20	4c. County of Death	2350 hrs
		Carroll Hospital Center	Westminster	catt	Caroline	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	· · · · · · · · · · · · · · · · · · ·		h(MM/DD/YYYY) 9. Birt Foreig	
Director		214-56-7372 1XM 2F 55	Yrs. Months Days Hours	Min. 1–28-	-1952 Co.	untry) MARYLAND
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Location			10d. Inside City Limits
<u> </u>			LTIMORE			1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
the Nation 3a or 2		2927 OAKLEY AVE.	21215		USA	
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	( Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
ter dea		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: BL	ACK
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	d by	or Dates:	6a. Decedent's Usual Occupation (Give kind		16b. Kind of Business/t	ndustry
27 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use	e retired)	4 10 101.301	
OO3 I withi	E O	-120-	LABORER	lame (First, Middle, M	CONSTRUC	TION
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur r event, the Medical Exam.	Bec	JOHN H. ADAMS SR.		RY LOVE	andon barriamo,	
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. 127 is marked other than " umatic event, the Medical	ė	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number		ber, City or Town, State	, Zip Code)
M akh		CYNTHIA ADAMS (WIFE)  20a. Method of Disposition 20b. Pla	2927 OAKLEY AVE.	BALTIMORE ,	MARYLAND 20c. Location - City or	
Baltimore, permit Pages I a Department of He important: If ite		1 Burish 2 X Cremation 3 Removal from State	matory or other place)			
Baltimore permit Pages I Department of E Important: If	-	4 Donation 5 Other Specifiy: METE 21. Signature of Funeyal Service Lisensee JONATHAN D. HI	RO CREMATORY 8	-8-2007	BALTIMORE,	MARYLAND
Ba Perm Depig Imp		Tout () Albre	1721-27 N. MONRO			
Physician		23 Part I. Enter the disease, or complications that caused the death. De failure. List only one cause on each line.				Approximate Interval Between Onset and
Medical xaminer	1	mediate Cause (Final disease condition resulting in death)	otic Cardiovascular Disease			Death
		Condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	iner	if any, leading to immediate cause. Enter Underlying Cause				
/ - =	Examiner	(Disease or injury that initiated events resulting in death) Last   C.  Due to (or as a consequence of):				
xecuted rand transit		d.				
760, icate be executed physician and the burial - transi	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnar	201		23d. Date of delivery	
		23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pr	regnancy		Day Year
Box 687 e death certific the attending of ed for use as the	ysician	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)			
that the d	/ Phys	Part II. Other significant conditions contributing to death but not resu	lting in the underlying cause given in Part I	. 23e. Did to	bacco use contribute to	the cause of death?
S, P.O. nires that the signed by doe detac	ed by	Chronic drug use		_	2 No 3 Prob	
cords, F aw requires nas been sign 2 should be	Completed		· · · · · · · ·	24a. Was a autops	sy prior to o	topsy findings available completion of cause of
tal Rec	E S			perfor		es 2 No
of Vital Records, ng Physician: The law requir Net this certificate has been s meral director, page 2 should t	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	26.Place of Death (Char)		Residence 6 Other	
of V ing Phy After th	1:1		Bb. Time of Injury 28c. Injury at Work?		now injury occurred	
Sion Attendir death. ctor: A	atio	1 Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	,		
Division of Vital Rec spital or Attending Physician: The I hours after death. neral Director: After this certificate I y filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Ru tate)	ral Route Number, City
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certifi 24 hours after death. Funeral Director: After this certificate has been signed by the attending redy filled in by the funeral director, page 2 should be detached for use as		29a. Certifier	death accurred at the time, date and place	and due to the source	o(s) and manner as state	od.
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.				
E > E 8	ğ.	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		(and Hellar	O.C.M.E.		August 3, 2007	
8		30. Name and address of person who completed cause of death (Item 23 Carol Allan, MD Assistant Medical Examiner 1	<sup>(a)</sup> 11 Penn Street, Baltimore, MD 2	1201		
	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	1 1 0			
Regist		3000	- AJOSAGES			
DHMH 17 Rev 1/20	001	OCME	ORIĞINAL			

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			Please Type or Print in Black Indelible Ink. Ensure A				gible.	
			State of Maryland / Department of Health and N  1- State Registrar Certificate of Death	Menta		40.0	**	1
		-	1. Decedent's Name (First, Middle, Last)	2. Date	e of Death	g. No.	-	3. Time of Death
	Physicia /Medic		Rosalie Augustyniak	Augu		Day	2007	-02:27 AM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death				unty of Death	1
			Union Memorial Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	To not	of Birth	n/		nplace (State or Foreign
	Funeral Director		218-36-2223 1 M 2 F 67 Yrs. Months Days Hours Min.	Jun	$e^{ith,Day}$	940	Cou	phace (state or Foreign intry) yland
	D D		Usual Residence of Decedent	, a				
	anylar show	ņ	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 No
	the N 28a-f notifie	rect	Md. Baltimore Dundalk  10e. Street and Number 10f. Zip Code		100	a. Citizen	of What Cou	untry?
	h with 23a or st be	Funeral Director	2037 Jasmine Road 21222				U.S.	Α.
	r deat ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes	or No-		Race - Amer Black, White	
20	be filed within 72 hours after death with the Maryland Hybjene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Year or Dates:			Spi	ecify: Wh	ite
5-0036	2 hou latura ical E)		15 Decedent's Education 16a, Decedent's Usual Occupation	al deserva	16	6b. Kind c	of Business/I	
7	ithin 7 se. tan "n Medi	Completed	(Specify only highest grade completed)  Elementary(Secondary (0-12) College (1-4or 5+)  (Give kind of work done during most of wor life. DO NOT use retired)	King				
7	filed within Hygiene. Ither than "	Cor	12th Graphic Artist  17. Father's Name (First, Middle, Last)  18. Mother's Nam	ne (First	Middle Ma		nting	5
and	d be f ental k ked of	To Be	Joseph Just		nowi			
Mary	2 should and Mer Is marke aumatic	_	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru	ıral Route	Number, (	City or To	wn, State, Z	ïp Code)
	t. ₹7 를 1		Bernard Augustyniak 7428 Bayfront Road	l Ba				
<u>o</u>	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 Bunial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  0 ak Lawn Cemetery 8-9-	Date			on - City or 1	rown, State , Maryland
Baltimore,			4 □ Donation 5 □ Other (Specify)  21. Signature of Fund Service Lieensee  22. Name and Address of Facility & C		- 1			
n	permit. Departr Importe any inju		1201 Dundalk Ave					
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respir	atory arres	st,		Approximate Interval Between Onset and Death
Ų.	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocardial Infarction					Offset and Death
•	/Medical Examiner		Due to (or as a consequence of):  Find stane Remai Di	\$0.00	<u></u>			>/4
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jee				
/	e executed ian and urial-transit	Examiner	that initiated events c.	æ				>1yv
ρ Q	death certificate be executed e attending physician and id for use as the burial-transit	_	Due to (or as a consequence of):					
289	death certificate be attending physici I for use as the bu	Physician/Medica	d					
X Q Q	th cert ending	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d.	Date of deli	
	the deal y the att ached for	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				Month	Day Year
J Ö	that the ed by detack		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23	e. Did toba	acco use r	contribute to	the cause of death?
g Q	w requires that the de been signed by the s should be detached	d by			1 ☐ Yes	3 2 N	lo 3□Pro	obably 4 Onknown
ecords	iaw requires that as been signed b 2 should be deta	Completed		24	a. Was an	2	4b. Were au	topsy findings available completion of cause of
r	The ate has page	Som		×	autopsy performe Yes 2	ed? □ No	death? 1 ∐ Yes	2XNo
VITa N	Physician: this certific ral director,	Be (	25. Was case referred to medical examiner?  Hospital: 4. Proceeding the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process o	ath (Checi	only one	)		
0	Phys r this ral dir	7	27. Mariner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Residen			cify)
VISION	Attending r death. ector: Afte by the fune	ation	1 Defeatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No					
S N	al or Attending Phys s after death. Il Director: After this d in by the funeral dii	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loc City	ation (Stre	et and Ni State)	umber or Ru	ral Route Number,
5	oital o urs aft eral DI		The board and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a death and a de		4- 41			-1-1-1
	To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by th	edical	29a. Certifier (Check only one)  1					
	To th within To th comp	Me	29b. Signature and the of certifier, 29c. License number			d. Date si	Δ	n, Day, Year)
)			AT 2438	946	1	Jugu	st 5	4007
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Efi Hessous Union Memorial Hospital	B	alliv	nove	2 /	MD
	Sta Registr		31. Date filed (Month, Day, Yéar) 32. Aggistrar's Signature					
	negisti	al	AUG 0 9 2007 Region to proceed					

		- 2	For State	ate of Maryland				Mental Hy	giene	
	-		Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	2. Date of De	Reg. No.	3. Time of Death
*	Physicia	_		oswell				Month	Day	Year 2:37 PM
	/Medic Examin	-	4a. Facility Name (If not institution, give street	t and number)		4b. City, Town,	or Location of Dea		4c. County o	
a.t.			Anne Arundel Med			Annapo				Arundel
Sec.	Funeral Director		5. Social Security Number 6. Sex 1	2X F 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days			y, Year) 1948	9. Birthplace (State or Foreign Country) Ohio
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryla f sho led at	ior	MD Anne Arundel	1 Seve	rna Pa	ark				1 □ Yes 2 No
	r 28a- notif	irec	10e. Street and Number	2 30.0		10f. Zip Code			10g. Citizen of W	hat Country?
	th with 23a o ist be	al D	16 Linstead Rd			21146			USA	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance.	/ Funeral Director	1 □ Never Married 2 Married 1	Nas Decedent Ever in U.S Armed Forces? □ Yes 2 X No f Yes, Give		Vas Decedent of f Yes, specify Cu I □ Yes 2X No	Hispanic Origin? ( ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	- American Indian, (, White, etc.
003	hours ural"; al Exa	d by		ear or Dates:	16a Dagar	lent's Usual Occu	Ination		16b. Kind of Bus	wnite
15	in 72 "nat	olete	15. Decedent's Educatio (Specify only highest grade con	mpleted)	(Give life. L	kind of work done OO NOT use retir	e during most of wo ed)	orking	TOD. KING OF BUS	miess/maasu y
212	d with giene. sr thai	Completed	Elementary/Secondary (0-12)	Callege (1-4or 5+) 5+	Nur	se			Healthca	are
Maryland 21215-0036	be filed all Hys at othe event,	Be C	17. Father's Name (First, Middle, Last)				1	me (First, Middle,	Maiden Surname	a)
yla	should t ind Ment s marked umatic e	ပု	John Roth				Joan De			
Mar	d 2 sh th and 7 Is m traum	1	19a. Informant's Name/Relationship (Type. F H. Wayne Boswell/Hush			•	et and Number or F Rd Severi			. ,
Ġ,	1 and Health tem 27 other tr		20a. Method of Disposition			sition (Name of natory or other pl		Date Date		City or Town, State
υOΠ	Pages nent of nt: If ii		1 ☐ Burial 2 【XCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	ival from State I			Inc. 8/6	0/07	Baltimor	e.MD
Baltimore,	permit. I Departm Importai any Injui		21. Signature of Funeral Service Licensee	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						
<u> </u>	e a E e	19	C. Tolley		29	99 Frede	ress of Facility Society rick Rd	Baltimore	e, MD 212	Ž <b>2</b> 8
j.			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final	ons that caused the death. ause on each line.	Do not ent	er the mode of dy	ring, such as cardia	ac or respiratory a	rrest, ViWaku	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		rowig	0,,,,,,	CODE 1	100000	9 years
	Examiner			Due to (or as a consequi	ence ory.					
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ence of):					
1	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for an a conseque	anno of):					
8760,	cate be executed physician and the burial-transit	a E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a consequent	ence ui).					
687	ficate physis the	edical	d							
Вох	h certi anding use a	M/m		if yes, outcome pf pregnar 1□Live birth 2□Fetal		Ectopic pregnan	01/			e of delivery
	law requires that the death certifit, as been signed by the attending to should be detached for use as	Physician/Me	1 Type 257 No	4□Pregnant at time of de 9□Unknown		Other (specify)			Mon	nth Day Year
P.O.	that the	Phy	Part II. Other significant conditions contribu	uting to death but not resul	ting in the ur	nderlying cause g	iven in Part I.	23e. Did t	obacco use contri	ibute to the cause of death?
ds,	uires t signe Id be	d by						1 🗆	Yes 2 No	3 Probably 4 □Unknown
000	aw req s beer s shou	lete						24a. Was		Vere autopsy findings available
Vital Records,	The lav	Completed						auto perfo	rmed? d	rior to completion of cause of leath? □Yes 212 No
ital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?			- 2		eath (Check only o	*	
7	Physician: this certific al director,	ပ္	1 Yes 2 No Hosp	1 Minpatient 2 L	R/Outpatien	I DOA		Home 5 ☐ Resi		
Division or	ding P h. After funer	Certification:	27. Manner of Death 2  1 ▼ Natural 5 □ Pending 2 □ Accident investigation	8a. Date of Injury (Month, Day Year)	Injury	W	uryai ork? ⊒Yes 2.∐No	28d. Describe	how injury occurre	ad .
Visi	Attending in death.	ifica	2 Noodelli	8e. Place of injury - At hor building, etc. (Specify)		eet, factory, office	•	28f. Location (		er or Rural Route Number,
ā	talor sae al Dir	Cert	Tomology	building, etc. (opechy)				Ony or ro	wii, Otale)	
	To the Hospital or Attending Ph within 24 hours a 'er death. To the Funeral Director; After th completely filled in by the funeral.	Medical	(Check only 2 Medical Examiner:	<ul> <li>In: To the best of my know On the basis of examination and manner stated.</li> </ul>						
	To the within 2 To the comple	Me	29h Signature and title of certifier			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
	,		> 7 Fleor	Ülsuo			14838		8/7/2	200+
	15		30. Name and addr ss of person who comple	eted cause of death (Item	23a) (Type,	Print) RO	Styate	Rd. A	unapol	1 (Month, Day, Year) 2007 115, Md.
	1 - 0		Stuart E. Selou	Registrar's Signat		70 130	9000	17		
	Sta Registi		TILC 0 Q 2007	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		A.s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 25,27,28a-I per me 2870,08709707dhb
Registrar 23aPtI,II Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year 0300 PM CHARLES BAER /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSVITA IMOR If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 213-30-7588 Director 76 04/28/1931 Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at show 10b. County 10d, Inside City Limits 1 TYes 2 No Director MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò traumatic event, the Medical Examiner must be 23a 3710 PIKESWOOD DRIVE 21133 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No NAVY If Yes, Give Year or Dates; items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 0 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: þ 3 Nidowed 4 Divorced natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES CLOTHING and Mental Hygier Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe IRVIN BAER ည ALMA GOLDSTINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is RICHARD BAER / SON LONGBOTTOM COURT, KINGSVILLE, MD Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BETH TFILOH CONG. 07/23/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any 500000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** schemic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner romary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): Examiner Hthero burial-trar Due to (or as a consequence of) AL EXAMINER attending physician CERTIFICATION APPROVED BY MEDICA Physician/Medical as the Box IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Feta! death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown he 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SAER CHITICES, Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes -2 2 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred **Subject driver of car collided** 27. Manner of Death 28b. Time of Certification: 5 ☐ Pending investigation Injury atural Accident 07/08/2007 2:31p. 1 Yes 2 **X**Vo death with pickup truck

281. Localion (Street and Number or Rural Route Number,
City or Town, State) Liberty Rd, at
Klee Mill Rd., Sykesville, MD within 24 hours after death To the Funeral Director: npletely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or Roadway 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as deads.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) the 20 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RINDER

AUG 0 9 2007

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** GRACE BAILEY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE CITY SINAI HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 220-14-2649 81 11/19/1925 Director MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at MD N/A XXYes 2 □ No BALTIMORE CITY Director be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6 5111 GWYNN OAK AVENUE 21207 USA Items 23a "natural", or Items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes \*\*\*No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ENOCH PRATT Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event, the once. BOOK BINDER LIBRARY (BALTIMORE) 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK BELLE WILLIAMS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5111 GWYNN OAK AVE., BALTIMORE, MD 21207 RONALD W. BAILEY SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/09/07 METRO CREMATORY CATONSVILLE, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD If nter the Asease, or complications that caused the death ck, or head ailure. List only one cause on each line. dying, such as cardiac or respiratory arrest, ause (Final **Physician** disease or condition resulting in death) /Medical Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed sician and burial-trans Due to (or as a consequence of): physician Physician/Medical the attending | 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 ☐ Unknown à contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2[**N**0 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 s autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 1 🔲 Inpatient ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29c. License number 29d. Date signed (Month, Pay, Year) leted cause of death (Item 23a) (Type, Print Ful the Baltimore MD

State

31. Date filed (Month, Day, Year) AUG 0 9 2007 Registrar



Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

or Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20b, perFH, G870, 8/9/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year BUSHROD DADIE AUGUST 2007 8:51 12M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHUS HOPKINS HOSPITAL CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Year) 26 1 ☐ M 2 ☑ F Director 12 80 05 NC 246-32-8186 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits be notified at Director 1 Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 972 North Franklintown Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 √Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Nidowed 4 Divorced er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant 12th grade Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Kitchen Earl Blackmon Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a Important: If item 27 is any injury or other trau 2403 E. Northern Pkwy, Baltimore, Md 21214 Dana Bushrod-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/7/2007 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet <del>8/8/07</del> Owings Mills, Md 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Larch F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** FAILURE disease or condition resulting in death) IHOUR /Medical Due to (or as a consequence of): Examiner 2 WEEKS STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed AORTIC ARCH ZWEEKS AUEURYSM burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an director, page 2 autopsy performe Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending thours after death. investigation 1 Yes 2 No 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certilier 29c. License number 29d. Date signed (Month, Day, Year)

5

State Registrar

31. Date filed (Month, Day, Year) AUG 0 9 200

JOWATHAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERGER

RES-006

AUGUST 2, 2007

			For State Registrar		State o	of Maryla	nd / Depa	artmen rtificat				/lental		ene g. No.	4.74 -9	SELA	
	Physici	an	1. Decedent's Name (First	st, Middle	, Last)							2. Date Mon	of Death	Day	Year	3. Time of Death	
	/Medio		Julia 4a. Facility Name (If not i	institution	, give street and nu	E .		4b. City,	Broy Town, or		of Death	5		4c. Count	of Death	G , 20   14M	_
	LAGIIII	ici	Gose		amarita	,		,,		4.mo							
	Funeral Director		<ol> <li>Social Security Number</li> <li>217-24-85.</li> </ol>		6. Sex 1 ☐ M 2 🗷 F	7. Age (In yr.	s. last birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date (Mon O1	of Birth th, Day, Y	Year) 31	9. Birthp	olace (State or Foreign ntry) MD	7
	and w		Usual Residence of Dece 10a. State 10b.	edent County		10c. C	City, Town or Lo	cation							1	10d. Inside City Limits	
-	Maryla f sho ied at	tor	MD	N A			Balt									1  Yes 2 No	
3	n 28a	Director	10e. Street and Number	INF	1		Dair	10f. Zip				_	100	g. Citizen of	What Cour	ntry?	-
Brown	death with the Maryland ms 23a or 28a-f show r must be notified at		937 North	Ros	sedale S	treet			21	216				U.	S.A.		
	er dea items ner m	Funeral	11. Marital Status		12. Was Dec Armed Fo	edent Ever in orces?		Was Dece	dent of Hi cify Cuba	spanic O n, Mexica	rigin? (Sp an, Puerto	ecify Yes Rican, et	or No-	14. Ra	ce - Americ ck, White,	can Indian,	
336	ırs aft al'', or 'xamîı	by F	1 □ Never Married 2 3 □ Widowed 4 🔀		ed 1 ☐ Yes If Yes, Gi Year or D	ive X Dates:		1 □ Yes	2 <b>X</b> ] No	Specify	<i>i</i> :			Specif	y: Bla	ck	
July 21215-0036	72 hou natura	Completed			's Education t grade completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ation	st of work	ina	16	6b. Kind of B	usiness/In	dustry	_
ا 12 م	vithin nne. han "	mple	Elementary/Secondary	(0-12)	College (	1-4or 5+)	ife. I	DO NOT u	se retired)	)		n ig					
	filed v Hygie other t		10th grade 17. Father's Name (First,		last)		OBG	YN I				e (First, M	fiddle, Ma	HOS aiden Surnar	pita ne)		_
/an	uld be Aental rked c	To Be			Unkn	own						, ,			Ú	nknown	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/P	Relationsh		Grand	19b. Mailir	ng Address	(Street a	and Numi	ber or Rur	al Route i	Number, (	City or Town	State, Zip	Code)	
	f and Health em 27 ther tr		Charles W:		ester -	Son	937	Nor	th I	Rose	dal	e St	I O	Balto	M	d 21216	
nor	ages ent of h t: If ite		1 ☐ Burial 2 ☐ Cre	mation		State	Place of Dispo cemetery, crer							Oc. Location		•	
Baltimore,	mit. Partme oortan injur		4 <sup>th</sup> Donation 5 □ c 21. Signature of Funeral			A	rbutus	Men 2. Name ar arch	Oria d Addres	al: s of Facil	8/1.	1/20	07 2	Arbut	us,	Md	-
ä	Depared Important Important Information	d	Tali	- /	Waret	~	M 4	arch 300	Waba	H We ash	ast Ave	, Ba	ltir	more,	Md	21215	
			23a. Part1. Enter the dis	ease, or	complications that conly one cause on	caused the dea	ath. Do not ent	er the mod	e of dying	g, such a	s cardiac	or respira	tory arres	t,		Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a	ardin		15							- 1	Onset and Death	
	Examiner			i i		(or as a conse		fore	مانات								
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118	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		C		MTN.										
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687	ificate g physi as the I	edical			d												_
Вох	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent preg		23c. If yes, ou	tcome pf preg	nancy tal death 3	]Ectopic pr	egnancy						te of delive	,	
Ö.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 montl 1 ☐ Yes 2 <b>☐</b> No 9 ☐ Unknown	ns?		nant at time of		Other (sp						Mo	onth	Day Year	
<u>α</u>	that the de led by the a detached f		Part II. Other significant	conditio	ns contributing to d	eath but not re	sulting in the ur	nderlying c	ause give	n in Part	1.	23e.	Did toba	cco use con	tribute to th	ne cause of death?	_
Division or Vital Records,	w requires that been signed to should be det	ed by											1 🗌 Yes	2 No	3 Prob	pably 4 Munknown	
ဝ၁	has bee	Completed										24a.	Was an autopsy	24b.	Were auto	psy findings available mpletion of cause of	
<u>=</u>	The cate had page											10	performe	ed?	death? 1 ∐ Yes		
V.it		o Be	25. Was case referred to examiner? 1   Yes 2 No	medical	Hospital:	the street of			Othe		e of Deatl						
ō	ding Phys	$\vdash$	27. Manner of Death		28a. Date		ER/Outpatien 28b. Time of		8c. Injury Work	4 L N				ce 6 □Oth injury occur		y)	-
sior	Attending r death. ector: After by the fune	atio	2 Accident	Pending investig	ation	uii, Day Teai)	Injury	М		r ∕es 2□	]No						
Σį	after death.  Director: /	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could no determine	ned 28e. Place buildi	of injury - At l ing, etc. <i>(Sp</i> ec	home, farm, stre cify)	eet, factory	, office			28f. Loca City	tion (Street Town, 1	et and Numb State)	er or Rura	d Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Ce	29a. Certifier 1 🖺 0	Certifying	Physician: To the	e best of my kr	nowledge, death	n occurred	at the tim	ne. date a	nd place.	and due f	to the cau	se(s) and m	anner as s	tated	-
	he Ho in 24 h he Fu pletely	edical	(Check only 2 N	Medicai E	Examiner: On the b	nasis of examination of the stated	nation and/or in	vestigation	, in my op	oinion, de	ath occur	red at the	time, date	e and place,	and due to	the cause(s)	
	To t To t	Σ	29b. Signature and title o	f certifier -	9				License				29d	I. Date signe		Day, Year)	
		-	00 Name == 1 = 11		JOHN MIN		4D		Res	0:30				5/5	1-7		_
(	1) 2		30. Name and address of	person v	who completed caus		em 23a) (Type, I	Print)									
	Sta		31. Date filed (Month, Da	y, Year)	10%	egistrar's Sigr										<u> </u>	-
	Registr	ar	ALIC	0 0	2007	allena e	H Los	well.									

#### **Physician** /Medical Examiner **Funeral** Director or 28a-f show notified at Director o e items 23a must by Funeral Examiner 5-0036 "natural", Completed 72 2121 1 and 2 should be filed withi Health and Mental Hygiene. Maryland Be ျှ permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau Baltimore,

**Physician** /Medical Examiner

law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, as nse for Jas Hospital or Attending Physician: this after death Director: To the Hospital or within 24 hours at To the Funeral D

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Janie T. Briggs 8:44 PM 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 5. Social Security Number 90 If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ √ Yrs 87 215-24-4575 Oct 14, 1919 So. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ **X**es 2 ☐ No **Baltimore** Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3222 Doycron Court 21207 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ Ng Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Company Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nero Felder Cora Felder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Summer Brook Court Huntsville, Alabama 35806 Jerome Tucker Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Byrial 2 ☐ Cremation 3 ☐Removal from State 08/10/07 Baltimore, Maryland 4 Donation 5 Dother (Specify) Arbutus Memorial Park 21. Si matura of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 LOUD Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhage biochostad 3 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown insuin dependent disbetes mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death? dementia autopsy rmed? 2 No performe 1 ☐Yes 2 ☑ No 25. Was case refe d to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-COO the in method-spectron 170 August 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. McHezl-Jackson itospital of Baltimore Mrekz 13/0 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State		Si	tate of N	Maryland				ealth a Death		ental Hy	gier	1	Ŧ	
Physiciar		Registrar     Decedent's Name (F	First, Middle,	Last)								2. Date of D Month	eath	Day \	/ear	3. Time of Death
/Medica Examine	1 -	4a. Facility Name (If no	rold ot institution, h Rich			er)	Barnet	4b. City,		Location		8	1	2007 4c. County of NA		8:30a <sup>™</sup>
Funeral Director		5. Social Security Num 213–36–19	ber	6. Sex	7.	Age (In yrs. I	ast birthday) Yrs.		r 1 Year	If Under Hours		8. Date of B (Month, D 3–16	rth ay, Yes -19	38	9. Birthp Cour	lace (State or Foreign trry) Md.
aryland show d at		Usual Residence of De 10a. State 10	0b. County	JA			, Town or Lo								1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the Mi	DIrecto	10e. Street and Number	er				barer	10f. Zij	p Code				10g.	Citizen of Wh	nat Cour	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral Director	11. Marital Status 1 □ Never Married	2 Marrie	12. \	Was Decede Armed Force 1 ☐ Yes 27 f Yes, Give	No No		_	edent of H ecify Cuba			ecify Yes or N Rican, etc.)	0-	14. Race Black, Specify:	White,	etc.
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours aff Department of Health and Mental hygiene. mportant: if item 27 is marked other than "natural" or my injury or other traumatic event, the Medical Examinance.	Completed by	(Specify	5. Decedent only highes	s Education	Year or Date on mpleted)	s:	16a. Dece	dent's Usu	al Occup	durina mos	st of worki	ing	16b	. Kind of Bus		
nd 212: e filed within all Hygiene. other than vent, the M	De Comp	Elementary/Secondary  9th grad  17. Father's Name (Fit	e		College (1-4d							(First, Middl	e, Maic	len Surname	)	
arylar Should by and Ments s marked sumatic en	0	Harold 19a. Informant's Name	e/Relationsh			Madde	19b. Mailir	•	•	and Numb		al Route Num			tate, Zip	
ore, M		Gerald  20a. Method of Dispos  1 Wengial 2 0	ition			other	lace of Dispo emetery, crea					Baltin Date	_	Location - C		own, State
Baltim permit. Pag Department Important: any Injury o		4 Donation 5 21. Signature of Fune	Other (Sp	ecify)	la ALa	M	1	2. Name a	nd Addre	ss of Facil	8-10	March B Jarch Balt	`.н.	undalk East re, Mo		21202
Physician		23a. /art1. Enter the sho k, or heart f Immediate Cause (Fir	dialo. List	complicationly one c	ons that cau ause on eac	sed this digate bline.				_			_			Approximate Interval Between Onset and Death
/Medical Examiner was used to be in and in and in a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	ıl Examiner	disease or condition resulting in death)  Sequentially list condition if any, leading to immediate (Disease or injutati initiated events resulting in death) Las	ury	b c	Due to (or	as a consequal as a consequal as a consequal	uence of):	4								
X 6 Certific certific se as	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ if 9 □ Unknown	onths?		1 Live birtl	me pf pregna h 2 ∐ Feta t at time of d	death 3	⊒Ectopic≀ ⊒Other (s		/				23d. Date Mon		ery Day Year
Cords, P.O. w requires that the de been signed by the s should be detached 1		Part II. Other significa	ant condition	ns contrib	uting to deat	h but not resi	ulting in the u	nderlying	cause giv	en in Part	1.				bute to t 3 ☐ Prol	he cause of death? bably 4 Dunknown
I Re la The la sate has page 2	Completed by	CHI										24a. Wa au pe 1∐ Yes	opsy formed	l? pi	rior to co	opsy findings available impletion of cause of
on o	lo Be	25. Was case referred examiner? 1  Yes No. 27. Manny of Death 1 Natural 2  Accident			28a. Date of		ER/Outpatie 28b. Time o Injury		28c. Injui Wor	er: 4 🗆 N	lursing Ho	h <i>(Check onl)</i> ome 5  Re 28d. Describ	sidence		r (Spec	HOGUC
Division al or Attending s after death. In Director: After ed in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determine	of be	28e. Place of building	injury - At ho , etc. <i>(Specif</i>	ome, farm, st	reet, facto	ory, office			28f. Location City or 7	(Stree own, S	t and Numbe tate)	r or Rur	al Route Number,
he Hospi in 24 hou he Funei pletely fil	edical	(Check only 2 one)	☐ Medical	g Physici Examiner	an: To the be On the bas and manne	is of examina	wledge, dea tion and/or ir	nvestigatio	on, in my	opinion, de	eath occur	and due to the time	e, date	and place, a	nd due	to the cause(s)
O T P P P P P P P P P P P P P P P P P P	Σ	29b. Signature and it	1/1/	Su	pul	2	000 /7/			e number	17	10	∠90.	Date signed	07	2
)_ Stat	e	30. Name and address 31. Date filed (Month,	TAV	wno comp	43	of death (Item pistral s Signa	ature		nd'i	M)	Z	3/16/	1		2/	2/8
Registra			116 0 0	2007	7	Maria a	K A	MALL	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #19b, perFH,0870, 8/9/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Brooks 8.04 30 AM the Μ. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Boutinere der 1 Year | If Under 24 Hrs. Yataruba Saltemore 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 □ M 2 Months Hours Min. Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No saltimore Saltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S.A rive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) idolDhus Ha Hall arrisa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown OVIVIA Brooks-Brown-Daughte 48 Millstone Moad MD 81133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/10/2007 Baltimore, MD Baltimore National Vaughor C. Greene purerus serves 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 728 Liberty Prd Mandellistern, mo 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute CAMPDIAC EVENT myocurdicul MINUTES Due to (or as a consequence of): Athero Scherotic CANDIOVASCU leur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 eccus Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? heart failure 1 Yes 2 No 3 Probably 4 Unknown reval 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No pelvic Maliquency 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation

Examiner or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760, physician the for use as signed by the a page 2 certificate this After

funeral director, death after death filled in by the

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumattc event, the Me

Physician

/Medical

Examiner

Physician/Medical

Completed by

Certification: To Be

Medical

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

6

within 24 hours a completely 10

State Registrar

6 Could not be

determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

13037

1 ☐ Yes 2 ☐ No

HUFUST

21215

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARK 6503 HE16HTS Robert M. Cooper 32. Registrar's Signature

AVE. BALTIMORE

			1- State of Maryland / [ Registrar	Department of Health and M Certificate of Death	lental Hygier Reg. t	200	2549;
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Bolleh		2. Date of Death Month 08	Day 07 Year 07	3. Time of Death 8: 22 AM
	Examir		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	•	4c. County of Death N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 218-58-8069 53	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10-8-195	9. Birthpl Count 3 M	ace (State or Foreign try) ARYLAND
	e Maryland Sa-f ehow	Director	Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow           MD •         N/A         BALT	m or Location			0d. Inside City Limits 1X Yes 2 □ No
	with th		10e. Street and Number 4552 DERBY MANOR DR.	10f. Zip Code 21215	10g. (	Citizen of What Count USA	try?
036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow after Exemitive Institute in this at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give X Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0036	d within giene. r then "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) -12- College (1-4or 5+) -0-	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  SCAFFOLDING	ing 16b.	Kind of Business/Ind	
Maryland 2	should be filed nd Mental Hygi i marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  JOHN BOLDEN		e (First, Middle, Maid BALLOU	len Sumame)	
Baltimore, Mary	permit. Pages 1 and 2 shou Depertinent of Health and M Important: If Item 27 Is mar any Injury or other traumat once.		ROSE BOLDEN (MOTHER)  20a. Method of Disposition  1 Wurial 2 Occumation 3 Deemoval from State  20b. Place o	JS MEMORIAL PARK 8–11	BALTIMOF 20c2007 BAI ILLIPS FUN	RE, MARYLA Location City or Too LTIMORE, M NERAL HOME	ND 21215 wn, State ARYLAND , P.A.
8760,	Cate be executed by Sicion and Character and Character and Character and Character and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate and Cate a	dical Examiner	23a. Party Enter the disease, or complications that caused the death. Do shopk, br heart failure. List only one cause on each line.  Immediate Cause (Final disease ov condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (pr as a consequence consequence)  Due to (pr as a consequence)  Due to (pr as a consequence)  Due to (pr as a consequence)  C.  Due to (pr as a consequence)	not enter the mode of dying, such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the such as cardiac construction of the s	or respiratory arrest,	T. Ala	Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certifics the has been signed by the attending ploage 2 should be detached for use as I	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3□Ectopic pregnancy 5□ Other (specify)		23d. Date of deliver Month	ry Day Year
	w requires that been signed b should be deta	ρ	Part II. Dther significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the	N.2
Vital Records,		e Completed	25. Was case referred to medical	OS Plans of David	24a. Was an autopsy performed 1 Yes 2	? prior to con death?	osy findings available inpletion of cause of 2 No
Division of Vi	ttending Phyedeath. ctor: After this y the funeral di	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	utpatient 3 DOA Cther: 4 Nursing Ho Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how in 28f. Location (Street	and Number or Rural	
Ö	Hospital or 24 hours after 5 Funeral Director illed in b	cal Cert	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place,	City or Town, Sta	o(s) and manner as sta	ated.
)	To the H within 24 To the Fi	Medicai	(Check only 2 Medical Examiner: On the basis of examination an and manner stated.  29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, L	
	6	•	30. Name and address of person who completed cause of death (Item 23a)  MID ATLANTIC CARDIO VAS  31. Date filed (Month, Bary, Year)  32. Sugerrar's Signature	100	REE RD. 7	BALTEMORE	MD 21208
	Sta Registi	- 4	ALIC O O 2007	Angell 1			

07-05980

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orei	nea burton		1- For State	State of	r Maryland / Dep C	ertificate of				a No		
	Physicia		Registrar  1. Decedent's Name	(First, Middle,Last)		ortmouto or	<del>Doda,,</del>		2. Date of Death			3. Time of Death
par .	al Exami	4117	Dore	thea.	Rurto	Al			Month August 4, 2	Day 2007	Year	1807 hrs
			4a. Facility Name (if	not institution, give s	treet and number)	4		wn, or Location of Death		4c. Co	unty of Death	ו
			Maryland Ge	eneral Hospital			Baltim					
	Funeral		5. Social Security N	umber 6. Sex	7. Age (In yrs	s. last birthday)	If Under Months		_	h(MM/DD/	Foreig	
	Director		212-84-	5291 1 M	1 2 🗶	Yrs.		Saye Missie Missie	3-14	1-190	60 CG	ountry) 11
a . 4,4 to		.··	Usual Residence of 10a. State	Decedent 10b. County	10c C	ity, Town or Locati	on				4	10d. Inside City Limits
	ow any		Ma. State	TOD. County	1	2011			•			1 Yes 2 No
	Maryland 28a-f show d at ouce.	ģ	10e. Street and Nun	nher		JUITIN	10f. Zip (	Code	10	g. Citizen	of What Cou	intry?
	e Mar or 28; ied a	Director	1204	Diago	A . 10		5	1517		1	1.54	_
1	eath with the litems 23a or ust be notifie	a	11. Marital Status	21495	12. Was Decedent Ever in	U.S. 13. Wa	s Deceden	t of Hispanic Origin? ( S	pecify Yes or No-	14.	Race - Amer	rican Indian, Black,
$\sim$	items	Funeral	Never Marrie	ed 2 X Married	Armed Forces?  1 Yes 2 No	If Y	es, specify	Cuban, Mexican, Puerto	Rican, etc.)		White, etc.	1 10
	fter d  ", or  er m	Y.	3 Widowed	4 Divorced If	Yes, Give Yaar or Dates:		Yes 2	No specify:		Spe	ecify:	Jack
	ours a	d by		lucation (Specify only	highest grade completed	16a. Deceden	t's Usual C	ocupation (Give kind of ing life, DO NOT use ret	work done	16b. Kind	of Business	/Industry
	6 72 h au "n ical E	ete	Elementary/Seco		College (1-4 or 5+)	10				I	211	c to
	5-0036 lled within 73 Hygiene. I other thau the Medical	Completed	47 Father's Name (			ITC	JU.	18.Mother's Name	e (First, Middle, N	Maiden Sur	name)	40
	filed al Hyg ed out		17. Father's Name (	A LO . H	)			Mac	7011	1.	Mod	ne l
	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at ouc.	To Be	19a, Informant's Na	me/Relationship (Typ	pe, Print ) (SON	19b. Mailing	g Address	(Street and Number or		ber, City o	or Town, Stat	e, Zip Code)
	MD id 2 sho lifth and m 27 is aumati		Kevin	E.G.II	1/AMS	1/20	4R	1995 AU	e, Ba	10	·MD	21217
	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene and in the firen 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp			<ul> <li>b. Place of Dispose</li> <li>crematory or ot</li> </ul>		e o ce metery,	Date	20c. Loc	ation - City o	r Town, State
	MOFE Pages 1 tent of F ant: If i			Other Specify:	Removal from State	1+710	MI Co	meters 8	3/11/01	B	Stil	nore, Mr
	Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Met			neral Service License		22(	The std	Address of Facility	1 Free	er	al Su	ru as
	<b>0</b> 2251		Jeron O.	Just In.	1700944		1ac	-112-16	215.5	tric	cres	Street
	Physician			ne disease, 🖈 complic ly one cause on each	cations that caused the den line.	ath. Do not enter t	he mode o	f dying, such as car liac	or respiratory arr	est, shock,	, or neaπ	Approximate Inferval Between Onset and
	Medical	PC 50	Immediate Cause (		Narcotic intox							Death
			or condition resulting	ng in death) Di	ue to (or as a consequent	e of):						
		ler	Sequentially list co if any, leading to in	nmediate Di	ue to (or as a consequenc	e of):						
		Examiner	cause. Enter Unde (Disease or injury t	hat initiated C.	ue to (or as a consequence	e of):						
V	ted J ansit	Exa	events resulting in	death) Last d.	ue to (or as a consequent	e 01).						
	execu an an	Medical	X UNPENDED		AMENDED #22	er fh g870	890	<b>7 vt</b> 70, 8/15/07 TI				
	60, ate be ohysici ne buri	Med	IF FEMALE:		#Z3a, Z/ 23c. If yes, outcome of p		nuc,go	70, 6/13/0/ 11		23d. [	Date of delive	ery
	687 ertifici ding p e as th	an/	23b. Was decedent past 12 months	pregnant in the s?	1 Live birth	f to set	etal death	3 Ectopic pregr	nancy	M	onth	Day Year
	Box 687 e death certific the attending p	Sici	1 Yes 2 🗸 I	No 9 Unknown	4 Pregnant at time of Unknown	or death 5 O	ther (Spec	cify)	-			
	the de	Physician/	Part II. Other signi	ificant conditions	contributing to death but n	ot resulting in the	underlying	cause given in Part I.	23e. Did t	obacco us	e contribute t	to the cause of death?
	P.C s that gned 1 e deta	ক্র			*				1 Ye	s 2 🗸 N	lo 3 Pr	obably 4 Unknown
	ds, equire een si ould b	Completed							24a. Was			autopsy findings available completion of cause of
	COF law r has b e 2 sh	[ 호								rmed?	death?	, ,
	Re: The fifcate f, page	3	25. Was case refer	med to medical				26.Place of Death (Check		2No	1 🗸	res 2 No
	Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rastier death.  an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	å	examiner?	Ho	ospital: Inpatient 2	✓ ER/Outpatien		Othor	sing Home 5	Residence	e 6 Oth	ner:
	of V g Physical diserted	<u>은</u>	1 ✓ Yes 27. Manner of Dea	2 No	28a. Date of Injury	28b. Time of		28c. Injury at Work?	28d. Describe	how injury	occurred	
	ath.	흲	1 Natural	5 Pending	(Month, Day, Year) Fnd 8/4/2007	Fnd 5:4	5 mm	1 Yes 2 X No	unk -			
	r Atte ter des irecto n by ti	liga	2 Accident 3 Suicide	Investigation 6 X Could not be	28e Place of Injury			, office building, etc.			Number or I	Rural Route Number, City
	Divitato urs afi	Certification:	4 Homicide	determined		at reside	nce		or Town, 1204 Ri	ggs Av	e. Balt	imore MD
	Hosp 24 ho Fune tely fi	al C	29a. Certifier	Certifying Physicia	n: To the best of my know	vledge, death occu	irred at the	time, date and place, ar	nd due to the cau	se(s) and	manner as st	ated.
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 🗸	Medical Examiner:	On the basis of examinati and manner stated.	on and/or investiga			at the time, date			
		ž	29b. Signature and	title of certifier	1/2		290	c. License number			·	Month, Day,Year)
				9	hul			O.C.M.E.		Augu	st 5, 2007	
	Ø		IV.		omplete cause of death (	Item 23a)	Street B	altimore, MD 2120	11			
			David Fowl		Medical Examiner	inature -	1	<del></del>			-	
	S Regis	itate strai		"AUG"0 9 2	2007 32. Radistrars Sig	mature A	rech	,				

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AMEND, TTEM#20b perFH, C870, 8/9/07 WS.
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death :31 AM 1. Decedept's Name (First, Middle, Last) Day Month **Physician** nnor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner A Year If Under 24 Hrs. 4105f Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Security 6 Sex Days Min **Funeral** 10 M 20 F Yrs 212-82-8030 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 1 Yes 2 No or items 23a or 28a-f ehow the Medical Examiner must be notified at BATT, MORE Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21.5.A 24166 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Yes, Give 1 Never Married 2 ☐ Married 1□Yes 2□No Specify: 6/Ack Specify: Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Be Completed by "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Depertment of Heelth and Mental Hygiene. Important: If Item 27 Ie marked other then 9th NONE (First, Middle, Maiden Sumag 18. Mother's Name 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Amues 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) M CALLAI AKBALA 20c. Li cation - City or Town, State 20b. Place of Disposition (Name of Baltimore, Method of Disposition cemetery, crematory or other place. Burial 2 Cremation 3 Removal from State Injury or Au quest 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee permit. Betts Funcial 2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, sata has baan signed by the ettending physician page 2 should be detached for use as the buria's Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DOOS Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2010 26. Place of Death (Check only one, To Be director 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours e 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore STREET RKES 2000 SONOVAN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0

2007

Gorale

32 Registrar's Signature

			For State Registrar	State of Maryl		artment of <i>rtificate c</i>				giene	U, I	1139111
		27 K	Decedent's Name (First, Middle, Las	1)					2. Date of De			3. Time of Death
	Physici		Emma H	Coleman	ı				Month	28, 20	S 7	0349 M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of	of Death	7-0	4c. County		,
	LACTION		Prince George	res Hospi	tal		here	rk		Princ	e 6	cours 5
	Funeral		5. Social Security Number 6. Se	x 7. Age (In )		If Under 1 Ye Months Da		24 H/s. Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
1	Director		249-50-8802	□M 2☑F 8	4 Yrs.		,,,	1	May 2,	1923		SC
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Le	ocation					1	Od. Inside City Limits
	sho	5										1 ☐ Yes 2 No
	the M	Director	SC Saluda  10e, Street and Number		Saluda_	10f, Zip Cod	Δ			10g. Citizen of W	Vhat Cour	ntrv?
	a or	늅		_		291				USA		,
	s 23	era	961 Denny Highway	12. Was Decedent Ever i	in U.S. 13.	Was Decedent of Yes, specify C		igin? (Spe	crfy Yes or No			can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exactions trained by notified at ance.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	-	If Yes, specify C			Rican, etc.)	Specify	k, White, Bla	
0	2 ho	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Oc	cupation	t of working	ng.	16b. Kind of Bu	siness/In	dustry
215	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work do DO NOT use re	tired)	N OF WORK	<i>'</i> 9	Nursing	3 <b>5</b>	
21	gien.	Son	7		Nurs	es Aide				Home		
nd	al Hy al Hy soth	Be (	17. Father's Name (First, Middle, Last)							Maiden Sumam	ө)	
yla	Ment Ment arked	ဥ	Willie Harp						Stever			
Maryland	2 she and is m		19a, Informant's Name/Relationship (7							er, City or Town,	State, Zip	Code)
	and ealth m 27		Greta C. Gallman -		961 b. Place of Disp	Denny H			uda, SC	29138 20c. Location -	City of T	own State
Ore	ges 1 t of t if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other	place)	8-3-0			•	SWII, State
Baltimore,	t. Pa rtmen rtant:		4 Donation 5 Other (Specify	<u></u>	Pine Ple	2. Name and Ad				Saluda, Son Fun		Ното
Bal	Depar Impo		21. Signature of Funeral Service Licent	Mun	3	06 Nort	h Boukr	night	Ferry	Road, S		a, SC 29138
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.								Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a con								
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587	ficate phys s the	edical		0								
Box (	certii nding use e	/Mc	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy					23d. Dat	e of delive	ery
ă	death a atte	Physiclan/Me	in the past 12 moons? 1 □ Yes 2 □ No	1 ☐Live birth 2 ☐ I 4 ☐ Pregnant at time		□Ectopic pregna □ Other <i>(specify</i>				Moi	nth	Day Year
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000	s been si s should	Completed							24a. Was	an 24b. \	Nere auto	ppsy findings available impletion of cause of
R	The lav	mo							auto perfo	ormed2	death?	2 No
Vital	ilclan: The certificete rector, pag	BeC	25. Was case referred to medical				26. Place	e of Death	(Check only			
<b>&gt;</b>	Physician: r this certificated director,	ToB	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 Nu	ursing Hor	ne 5□Resi	dence 6 Oth	er (Specii	(v)
u of	iding Physician: th. After this certifice funeral director, p		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. I	njury at Work?	2	28d. Describe	how injury occurr	ed	
<u>Ö</u>	Attending or death.	atlc	2 Accident investigation				1 □ Yes 2 □	No				
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st pecify)	reet, factory, offi	ce	2	28f. Location ( City or To	Street and Numb wn, State)	er or Rura	al Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		ysician: To the best of my iner: On the basis of exar and manner stated.								
_	To the within To the comp	Ž	29b. Signature and title of certifier	10 +		29c. Lic	ense number	-		29d. Date signed	1 (Month,	Day, Year)
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1	2		30. Name and address of person who co	completed cause of death	(Item 23a) (Type	Print)	me, c	Cho	very.	Man	gla	d
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Section   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue	xecute and		Yall	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)	e of).				
FEMALE:   23c. If yes, outcome pf pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   1   Year   2   No   9   Unknown   1   Year   2   No   9   Unknown   1   Year   2   No   9   Unknown   2   Month   Day   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Year   2   Y	760 e be e sician b buria		<u>a</u>	d	0 01).				
28b. Was decedent pregnant in the past 12 months? 1   25c. In yes, solutioned pit pregnancy   1   25c. In yes, solutioned pit pregnancy   1   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes   25c. In yes	- F 500			IS SERVICE.					
Athia Fibrillation    1   Yes 2   No 3   Probably 4   Unknown	Sox ath ce ath ce ttending or use	5	0	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea		<i>y</i>			•
Athia Fibrillation    1   Yes 2   No 3   Probably 4   Unknown	the d		ysic	1 Yes 2 No 4 Pregnant at time of death	5 ☐ Other (specify) _			World	Day
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of Injury  28. Death of	s that med by e deta	Č	L Á		in the underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
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m	ga S		Decedent's Nam	ne (First, Middle, La	ast)					2. Date of De	eath		3. Time of Death
	Physicia		LIND	A and	2NELL					Aubust	7 Day	2007	0312 AM
	/Medic Examin	2000			ve street and number	)		4b. City, Town, o	r Location of Dea			County of Deat	
3			Northwe	est Hosni	tal Cente	r		Randal	.lstown			Baltimo	re
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	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10090 Mi	11 Run C	ircle A-4	<b>₊</b> 1Π		21117			US	Д	
	ms 2	ners	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Decedent of H		Specify Yes or No		4. Race - Amei	
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V	within the the Me	ᇤ	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	_	istered N			Ha	alth Ca	TO.
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<u></u>	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meore.	욘		lame/Relationship	(Type, Print)		19b. Mail	ing Address (Street					lip Code)
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ē,	f Hea		20a. Method of Dis	position		20b. P		osition (Name of ematory or other pla		Date		cation - City or	
Baltimo	Page ent or nt: If i				☐Removal from Stat			Svc. Cor		/09/2007	Тош	son, Ma	rvland
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ă	Dep		Mush	aA.		_		1050 York	Road,	Towson, 1	Maryl	and 2	1204
b	- N		23a. Part1. Enter	the disease, or cor	nplications that cause y one cause on each	ed the death	n. Do not er	nter the mode of dyi	ng, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause	(Final		WD							Onset and Death
V	/Medical		resulting in death)	-	Due to (or a		uence of):						
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gox	atten for u	cian	23b. Was deceder in the past 12	2 months?	1 ☐Live birth 4 ☐ Pregnant	2 🗆 Feta	I death 3	□Ectopic pregnanc □ Other (specify) _	у		-	Month	Day Year
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7	that ned by deta		Part II. Other sign	Ificant conditions	contributing to death	but not resu	ulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
cords	quires n sign	d by								1 🗆	Yes 2	]No 3∏Pr	obably 4 Donknown
္ဌ	law requires that as been signed b 2 should be deta	lete								24a. Was		24b. Were au	topsy findings available
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0	ng Ph ter th		27. Manner of Dea	th 5 □Pending	28a. Date of In (Month, E	jury Da <i>v Year</i> )	28b. Time Injury	of 28c. Inju	ry at rk?	28d. Describe	how injury	occurred	
SION	Attending r death. ector: After by the fune	Certification:	2 Accident	investigation	on				Yes 2 □ No				
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2	ital or ral D lled ir												
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)		hysician: To the bes mlner: On the basis and manner:	of examina							
	the ithin 2 the orthogonaple	Mec	29b. Signature and	d title of certifier	and manner	stateu.		29c. Licens	se number		29d. Date	e signed (Mont	h, Day, Year)
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,	¥		30. Name and add	ress of nerson who	completed cause of	death (Item	23a) (TvrP						•
	6	-	DI. James	Howle	un 540)	ad()	FRd.	Raidalls-	town Mi	D 21133			
	Sta	ite	31. Date filed (Mo		32 Regis	trar's Signa	ture						
J.	Registr	ar	Α	UG 9 20	107	w L	1 19	Randa Ws-					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month CERVANT WILLIAMSON 12:15 AM 8 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner columbia aenosal Hospital Howard County HOWARD MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 79 Sept. 6, 1928 MO Director 491-32-4481 10a State 10b. County 10c, City, Town or Location 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 6378 Rowanberry Drive 21075 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Completed by Specify Specify: white 3 Widowed 4 Divorced Year or Dates: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) If item 27 is marked other than "n v other traumatic event" Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oval C. Williamson Velma Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 6378 Rowanberry Drive Elkridge MD 21075 <u> John H. Cervant/Husband</u> 20b. Place of Disposition (Name of cemetery, crematory of other place) West Arundel Crematory 8-4-2007 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ACremation 3 □ Removativirom State 4 □ Donation 5 □ Other (Specify) Odenton, Maryland At prose funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 2 Signature of Funeral Services Linuse Part I inter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** of Joseph Due to (or as a consequence if): /Medical **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-trans law requires that the death certificate be exect Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 146 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **♥**■Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

ospital or Attending Phy:
hours after death.
uneral Director: After this
ly filled in by the funeral di To the Hospital within 24 hours a To the Funeral C completely filled in

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Edad lane, Columbia, MD-21044 SRILATHA KANUMURU 5755 Registrar's Signature 31. Date filed (Month, Day, Year) State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0064539

29d. Date signed (Month. Day, Year)

Registrar

Medical

AUG 0 9 2007

29b. Signature and title of certifier

K. Sc. Cattra MD

29a, Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1☑M 2□F Months Days Hours Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Leryes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race 11. Marital Status 1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any injury or other traumatic event the "" once. Elementary/Secondary (0-12) College (1-4or 5+) ather's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 20c. Location - City of Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation/ 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. P. M. Intel tree sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Vuse (Final Physician disease or condition resulting in death) /Medical Due to (or as a convequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit 14 7 Due to (or a consequence of): physician s the burial Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Memor (Specify) SKINO Medical Certification: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA after death.

I Director: After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Attatural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in

certificate be exec Box 68760, Division or Vital Hospital or Attending Physician: items 23a or 28a-f show

"natural", or

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifler

certificate

this

31. Date filed Month, Day, AUG 09

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	2. Registra	ar's Signatu	ire /
	Fra	20	1
Š	March Street	Sofo	AND SOLD

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year)

algna of e and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

(ames

31. Date filed (Month, Day, Year)

32 Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

s Signature

Registrar

Hospital

2007

Demetrius Downing	7. Sr. State of Masyland Department of Health and Mental Hygiene 1- For State 18 per fh Registrar 18 per fh Reg. No.  1. Decedent's Name (First, Middle,Last)  2. Date of Death 3. Time of Death 3. Time of Death	
Physician Medical Examine	Month Day Year	
Print,	4a. Facility Name (If not Institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
Samuel .	University Hospital Shock Trauma  Baltimore  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or	
Funeral Director	218-98-3289   1X M 2 F 25 Yrs.   Months   Days   Hours   Min.   12/19/1981   Foreign Country)   MD	
any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
-f show	MD BALTIMORE CATONSVILLE  1 1 Yes 2 X 1  10e. Street and Number  10f. Zip Code 10g. Citizen of What Country?	No
th the Maryland  23a or 28a-f sh  24 ontified at one		
IMOTE, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiele with a structural, or items 23a or 28a-fath or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director		
nours aft	10 Dates:	
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) ROOFER CONSTRUCTION	
15-0036 liled within 7 Hygiene. d other than the Medica		_
2121 2121 Juld be fi   Mental   marked ic event,	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_
MD and sho alth and m 27 is aumatin	CORDELIA FRAZER / MOTHER   1000 SOUTHRIDGE ROAD, CATONSVILLE, MD 228	}
Ore, ges I an t of Hea : If ite	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  METRO CREMATORY  20b. Place of Disposition (Name of cemetery, crematory or other place)  METRO CREMATORY  8/02/07  CATONSVILLE, MD	
Baitimore, MD 21215-003 permit. Pages I and 3 should be filed with Department of Health and Mental Hygiene Important: Iritem 27 is marked other Initury or other traumatic event, the Med To Re Comm	4 Donation 5 Other Specify: OTHER OF CREMATORY OF CATOMS VILLE, MOVELL FUNERAL HOME 21.20 Name and Address of Facility HOWELL FUNERAL HOME 21.20	7
	4600 LIBERTY HEIGHTS AV, BALTIMORE, ME 23a/Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inter	_
Physician /Medical	failure. List only one cause on each line.  Interpretations that caused in sease a gunshot wound of left ear and head  Between Onset at Death  Death	
Examiner	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
led Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  CERTIFICATION APPROVED BY MEDICAL EXAMINER  d.	
	d. CERTIFICATION	_
60, ate be execu hhysician and the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 6876: death certificathe attending phed for use as the	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Specify)  Month Day Year	
Deviciorant	1 Ves 2 No 9 Linknown	
P.O. ires that the signed by I be detach	1 Yes 2 No 3 Probably 4 Unknow	/n
Records, The I-w requires ficite has been sig	24a. Was an 24b. Were autopsy findings availa autopsy prior to completion of cause	
Recol	performed?   death?   1	
Vital Records, ysician: The L-w require this certific te has been a director, page 2 should 1	25. Was case referred to medical  examiner?  Hospital: 4 Inpution 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:	_
n of Vit ding Physic h. After this	27. Manner of Death 288. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division as or Attending a Brice death.	1 Natural 5 Pending Investigation 2 Accident Subject Shot 1 Yes 2 No Subject shot 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Company of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of	- City
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The I-w requires that the death certificate be 24 hours after death.  Each near Director: After this certificate has been signed by the attending physicitety filled in by the funeral director, page 3 should be detached for use as the burial of Cartification: To Be Completed by Divisional Medical Machine and Cartification: To Be Completed by Divisional Medical Machine and Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medi	3 Suicide 6 Could not be determined (Specify) Home  286. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 297. Decarding (Street and Number of Kurar Koule Number, Corr Town, State) 298. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, State) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, street, factory, diffice building, etc. or Town, state) 299. Place of Injury - At nome, farm, s	,ity
the mple	28a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
F. 18 5	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
-(3)	30. Name and address of person who completed cause of death view 23a)	
	Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra		
DHMH 17 Rev 1/200	AUG 0-8 2001 Julies 2001	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 2<u>007</u> **Physician** RAYMOND DEPAUL JUL 31 9:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1X M 2 ∏ F 189-16-0264 Director 84 Dec.22,1922 PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Loudoun Hamilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Examiner must, one. 39958 Charles Town Pike 20158 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fighter Pilot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond DePaul ဥ Anna Marie Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanche M. DePaul-Wife 39958 Charles Town Pike, Hamilton, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria ☐ 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation \5 □ Other (Specify) 8-2-07 Alexandria, VA 21. Sign ure of Fureral Service Licensee 22. Name and Address of Facility Hall Funeral Home PO Box 896, Purcellville, Virginia 20134-0896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as nse IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred Injury at Work? After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 ELEXIS C MCBEE Date filed (Months, Day, Year) MC USN

32. Registrar's Signature

ORIGINAL

2007

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State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 11a. State 10b. County 11b. Laurel 11c. State 11c. Street and Number 9215 Apt. F Traders Crossing 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Mar	9. Birthplace (State or Foreign Country) Philippines  10d. Inside City Limits 1
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Funeral Director    214-47-2403	Country) Philippines  10d. Inside City Limits 1
10a. State   10b. County   10c. City, Town or Location   Laure   10c. City, Town or Location   Laure   10c. Street and Number   9215 Apt. F Traders Crossing   20723   10c. City or of War   10c. City or of Location   10c. Street and Number   9215 Apt. F Traders Crossing   20723   11. Marital Status   11. Never Married 2 Married   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or Location   10c. City or Town or It Yes, specify Cuban, Maxidan, Puerfo Rica, Marie   10c. City or Town or It Yes, specify Cuban, Maxidan   10c. City or Town or It Yes, specify Cuban, Maxidan   10c. City or Town or It Yes, specify Cuban, Maxidan   10c. City or Town or It Yes, specify Cuban, Maxidan   10c. City or Town or It Yes, specify Cuban, Maxidan   10c. City or Town or It Yes, specify Cuban, Maxidan   10c. City or Town or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and City or It Yes and	Nhat Country?  USA e - American Indian, ok, White, etc.  ✓ Filipino usiness/Industry  .c Church ne)  State, Zip Code) . MD 20723 . City or Town, State re, Maryland
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Elementary/Secondary (0-12)   College (1-4or 5+)   Priest   Catholi	e - American Indian, ok, White, etc.  Filipino usiness/Industry  C Church ne)  State, Zip Code) MD 20723 City or Town, State re, Maryland
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Elementary/Secondary (0-12)   College (1-4or 5+)   Priest   Catholi	State, Zip Code) MD 20723 City or Town, State re, Maryland
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Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	nome, r.A.
Physician /Medical Examiner  Page 1 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10 of 10	20707 Approximate
FFEMALE: 23c. If yes, outcome pf pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Date   23d. Dat	ate of delivery onth Day Year
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autopsy performed? 1 □ Yes 2 No	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical examiner?  Hospital: 1   Inpatient   2   ER/Outhatient   3   DOA    Other: 4   Nursing Home   5   Residence   6   Moth	HAS is
1   res 2   No   1   Impatient 2   EH/Outpatient 3   DOA   4   Nursing Home 5   Hesidence 6 A Oth	rred
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

			For		,	State o	f Maryl	and / D	epartm	ent of H	Health and	Mental	Hygiei	ne											
		•	State Registrar						Certific	ate of	Death		Reg.	No.	*	951, 13									
P			1. Decedent's Nam	e (First, Midd	le, Last)							2. Date of		Day Y	ear	3. Time of Death									
	Physici /Medic		Anna Mar	ietta I	ruin							Aus		420		19:07									
極	Examin	20	4a. Facility Name (	If not institution	n, give str	eet and nur	mber)	. ,	4b. (	ity, Town, o	or Location of De	ath		4c. County of	Death										
			<i>DT. 1</i>	19n	) 95	1	35p,	yrs. last birtl	hday) If U	der 1 Year	If Under 24 H		of Righ		Birthn	lace (State or Foreig									
ı	Funeral Director		5. Social Security N	652	6. Sex 1 ☐ I	/ 2 <b>∑</b> F	7. Age (in )	\	rs. Mon		Hours Mi		n, Day, Ye	ar)	Cour	ryland									
	and w		Usual Residence o 10a. State	10b. County	/		10c.	City, Town	or Location						1	0d. Inside City Limit									
	Maryl f sho	Ď	MD	Balt	imore		Laı	nsdowr	ne							1 □Yes 2XN									
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nu 406 Burba		ırt					Zip Code 1227				Citizen of Wh	at Cour	ntry?									
	ms 2; mus	nera	11. Marital Status		12		edent Ever i	n U.S.	13. Was D	ecedent of I	Hispanic Origin? oan, Mexican, Pu	(Specify Yes o	or No-	14. Race - Black,											
980	urs after al", or ite	by Fui	1 ☐ Never Mar			Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 <b>X</b> No ve			s 2X No	Specify:	erto i noari, etc	.,	Specify:											
Ö	72 ho natur lical l	ted	(Soe	15. Decede	nt's Educa	ition		16a.	Decedent's	Jsual Occu	pation during most of w	orking	16b	. Kind of Busin	ness/In	dustry									
21215-0036	2 should be filed within and Mental Hygiene. is marked other than "aumatic event, the Mec	Completed by	Elementary/Second 12			College (	1-4or 5+)	Sup	ilife. DO NO Dervis					ecurity	,										
Maryland	be file ad oth event	8e	17. Father's Name											den Surname)											
	should I and Men s marker umatic	욘	Charles					1.00	A 4 12 A 4	(0)	Camilla			it as Town Co	ata Tie	Cadal									
	12 sh hand rism raum		19a. Informant's N								t and Number or				аге, иг	(Code)									
	1 and 1 Health em 27 ther tr		Douglas (		in/Hu	sband	20	b. Place of	Disposition	Name of	ourt Lar	ISCIOWNE Date	MD 2	Location - Ci	ty or To	own, State									
nor	Pages nent of I int: If ite		1 ☐ Burial 2	Cremation		moval from	9 tate W	est Ai	y, crematory cunde l	or other pla	atory 8-	-9-07	Ode	enton,	Mar	yland									
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Sunatur of F		-	A	OUIA	FA	22. Nam	e and Addr Se Fu	ess of Facility neral Ho	ome_of	Lanso	lowne	m 0	1227									
	2010		23a, Part , Exter	the disease.	or combine	ations that of	aused the	death. Do n	ot enter the	Hammo mode of dy	nds Fern ing, such as card	y KO. liac or respirat	Lanso ory arrest,	lowne M	ID Z	Approximate Interval Between									
100	Physician (Madical		show or he Immediate Cause disease or condition resulting in death)	(Final on	st only one	cause on e	CUT	EM	40 CA	RDI	AL ISC	HEMI	4			Onset and Death  2 -3   +R-									
	/Medical Examiner		,			Due to	(or as a con	isequence d	1): 4724	ansc	LEROSI	5				YEARS									
18	pel list	al Examiner	al Examiner	al Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	onditions mmediate erlying r injury	b.	Due to	(or as a con	sequence o	it):					9									
8760, 7	cate be executed oblysician and the burial-transit				al Exan	al Exar	al Exan	al Exan	al Exan	al Exan	al Exan	al Exan	al Exan	al Exam	that initiated event resulting in death)	ıs	c.	Due to	(or as a cor	sequence o	rf):				
687	ficate phys s the	edical			d.		-							1											
Box	law requires that the death certificate as been signed by the attending physional be detached for use as the	siclan/Me	Physician/Med	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknow	2 months?	23	1□Live	nant at time	Fetal death		ic pregnand r (specify) _	су		_	23d. Date Mont		ery Day Year								
P.0	that t ed by detac	F.	Part II. Other sign	ificant condi	tions cont	ributing to d	leath but not	t resulting in	the underly	ng cause gi	iven in Part I.	23e.	Did tobac	co use contrib	ute to t	he cause of death?									
ds	uires sign Id be	d by	MORB	10 08	ESIT	4						_	1 ☐ Yes	2 No 3	☐ Pro	bably 4 □Unknov									
Records,	e law requii has been s je 2 should	Completed		CHIAC								- 1	Was an autopsy performed	24b. We	ere auto	opsy findings availab ompletion of cause o									
a F	: The cate h			RIENS		CARLO	IOVAS	CUCAR	DISE	ASE		1200	es 2	No 1	ath? Yes	2□No									
<b>*</b>	Physiclan: r this certific ral director,	Be	25. Was case reference examiner? Yes 2			ospital:	Ameticat	2 ER/Out	tnationt 2	1 DOA Ot	her	Death (Check		e 6 □Other	/Canai	6.1									
ō	ding Physician: The I h. After this certificate ha funeral director, page	: To	27. Manner of Dea			28a. Date	of Injury	28b. T	ime of	28c. Inju	4 🗀 INUI SITI			injury occurred		19)									
on	Attending r death. ector: After by the funer	tion	1 XNatural 2 ☐ Accident	5 Pend	ing tigation	(Mor	nth, Day Yea	a <i>r)</i> Ir	njury M		ork? ]Yes 2∐No														
Division or Vital	il or Atter after dea I Director d in by the	ertifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deter	d not be mined	28e. Place build	e of injury - , ling, etc. (S <sub>l</sub>	At home, far	rm, street, fa	ctory, office	)		tion <i>(Str</i> ee or Town, S		or Rur	al Route Number,									
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one)	1 Certify 2  Medica	ing Physi al Examin	er: On the b	e best of my pasis of exa nner stated.	knowledge mination an	, death occu d/or investig	rred at the ation, in my	time, date and pl	ace, and due t ccurred at the	o the caus time, date	se(s) and man e and place, ar	ner as s	stated. to the cause(s)									
	To the within 2 To the complet	Me	29b. Signature an	d title of certif	ier	2 0	1 - 1	11		29c. Licen	se number		29d.	Date signed	Month,	Day, Year)									
			> Ca	is n	1.	the	lut	the	mo	DO	00373	359	A	U6UST	6	,2007									

Mix M. Sheluthamo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUGUST 6, 2007

A MD QUO CATON AVE BALTIMORE, MD 31239 M. SHEKITKA KRIS M. SH 31. Date filed (Month, Day, Year)

AUG 0 9 2007

Registrar

# Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, <

		Please Type or Print in Black Indelible ink. Ensure Al			
		State of Maryland / Department of Health and M	1ental Hygi	ene	
		1 - State Amend #30, perDVR, g870, 8/9/07 TTCertificate of Death		g. No. ,	33 19 1
Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
/Medic	cal	MARIE DAWKINS	August	3,2007	18:10 M
Examir	ier	4a. Facility Name (If not institution, give street and number)  Northwest Hospital Center RANDALLS TO		4c. County of Death	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	IS ALTIA	ace (State or Foreign
Funeral Director		7110.91).87110 1 M X F SI Yrs. Months Days Hours Min.	(Month, Day,	Year) 1915 VA	try)
A		Usual Residence of Decedent	0100	1121 11	
rylan how	_	10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
e Ma 3a-f s tiffiec	cto	MD baltimore handellotain			1 □ Yes 2 Dolo
ith th or 23	<b>Funeral Director</b>	10e. Street and Number	10	g. Citizen of What Coun	try?
ath w	ral	4720 Eutice hoad 21133		USA	
er de item:	n.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, of	
rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Year or Dates:		Specify: 21	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ed	15. Decedent's Education 16a, Decedent's Usual Occupation	1	6b. Kind of Business/ind	ustry
nin 72 n "nii Medi	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary(\$econdary (0-12) College (1-4or 5+)	ing		,
d with giene rrtha the l	mo;	Domestic		Domestic	
al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name	e (First, Middle, M	laiden Surname)	
uld be Mental rked o	To	Nellie T	Davis		
2 should and Mer Is marke		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Run	al Route Number,	City or Town, State, Zip	Code)
and and and n 27 n 27 ner tra		Wette D. Dauhins/Daugher 19720 Entice and hair	1delliste	aun MO a	1133
of He fiten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	0c. Location - City or To	wn, State
Pages ment of I ant: If ite ury or o		4 Donation 5 Other (Specify) ( -arrison fores) 08.10	· 2007 0	wings mill	s.mD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ighn C. G	recre funera	i Service
2 A E 8 6				tour mo 21	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Cerebrovascular Accide	ent		Onset and Death
/Medical Examiner		Due to (or as a consequence of):			. 1
Examiner	_	Sequentially list conditions, b. Right MIDDLE CEREBRAL ART	ERY TH	LOM BOSIS	36 hours
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1		1000
xecuti and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			years
be exician buria	calE	Due to (of as a consequence or).			
physicate physicate		d			
The law requires that the death certificate I ate has been signed by the attending physioage 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23c. If yes, outcome pf pregnancy		22d Date of delive	
eath atter for u	ciar	in the past 12 months?		23d. Date of delive Month	Day Year
the d y the ched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
w requires that the debeen signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
luires nesigr	d by	DIABETES MELLITUS	1 ☐ Ye	s 2☑No 3□Prob	ably 4 Unknown
w rec s beel shot	lete	HYPERTENSION	24a. Was an	24h Were autor	osy findings available
he la e has	Completed	1/1/2012/03/07	autopsy perform	prior to con death?	npletion of cause of
		25. Was case referred to medical 26. Place of Death			2 No
/sic/a	o Be	examiner?		nce 6 Other (Specify	a a
ding Physician: The lav n. After this certificate has funeral director, page 2:	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe hov		/
ndin ath. r: Aft e fun	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Rura	Route Number,
tal or s afte al Din ed in	Certification:	Saliding, vic. (Specify)	City of Yown,	Siale)	
ospil hour uner		29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the ca	use(s) and manner as st	ated.
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, I	Medical	one) and manner stated.			
Vith To 1	Σ	29b. Signature and title of certifier 29c. License number		d. Date signed (Month, I	
		Marry MI Di0718	/	lugust 4	2007
lo		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	· · · · ·		
		Harry M. Walen, MD Northwest Hospital Center Randallstown, MD			
Sta Registr		31. Date filed (Month, Day, Year) AUG 0 9 2007 32. Registrar's Signature			
negisti	ai	nou v v - /			

			For State Registrar	State of Mar	yland i Bepa Cer	ਜਿ <del>ment</del> of የ tificate of			giene Reg. No.	ger.	951,50
			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
10	Physicia /Medic		Agnes (	c. r	Dobrzyck	i		Augus		007	11:40A. <sup>™</sup>
	Examin		4a. Facility Name (If not institution, give s	treet and number)	•	4b. City, Town, o	r Location of Death		4c. County	of Death	
			930 S. Curley St	reet		Balti				N/	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp	olace (State or Foreign ntry)
20.54	Director		219-40- <del>4144</del>	]M 2 <b>⊠</b> F	63 <sup>Yrs.</sup>			2-9-19	)44	Mar	yland
	P .		Usual Residence of Decedent		10c. City, Town or Lo	ration					10d. Inside City Limits
	arylai show d at	١	10a. State 10b. County		roc. ony, rown or co.	Julion					1√2 Yes 2 □ No
	Ba-f	5	MD N/	'A	Ва	altimor	e		10g. Citizen of V	Mhat Cou	ntn/2
	or 2	ä	10e. Street and Number			10f. Zip Code	0.4				muy:
	ath w	Ta	930 S. Curley St		110 110	212		noify Voc or No	USA 14 Bac		can Indian,
	tems	Funeral Director	11. Walital Status	12. Was Decedent Ev Armed Forces?	'	f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White,	
36	or i		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	I□Yes 2√∏No	Specify:		Specify	√ Whi	ite
8	hour tural	Completed by	15. Decedent's Educ		16a. Deced	lent's Usual Occup	ation		16b. Kind of Bu	usiness/Ir	dustry
7	"na"	lete	(Specify only highest grade	e completed)	(Give	kind of work done OO NOT use retire	during most of world)	king	Baltin	nore	City
12	withii ene. than he M	m	Elementary/Secondary (0-12)	College (1-4or 5+)		Secreta	r v	-	Police		
22	Hygi ther ther		17. Father's Name (First, Middle, Last)	11/ 21		Jecreta	18. Mother's Nam				
au	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Be c	Frank J. Giza				Lillia	an A. 1	Brykows	ski	
2	hould Me mark matic	٩	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailin	g Address (Street	and Number or Ru				o Code)
<u>≅</u>	d2s than than 7 is trau	1 8	Lisa M. Schillir		ter   7347	7 Green	bank RD	. Balt:	imore,	MD	21220
a)	1 an Heal em 2	,	20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location -	City or T	own, State
٥	ages nt of tif it		1 ☐ Burial 2 【XCremation 3 ☐ R	lemoval from State	Bayview		1	2007	Rol+i	more	n MD
Baltimore, Maryland 21215-0036	it. Pi		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License								1 Home, P
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Talial M				dalk Ave				
		-	23a. Part1. Enter the disease, or compli	ications that caused t							Approximate Interval Between
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	<i>.</i>						Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	HEAN?		ACH				_	
					consequence of):						
		7	Sequentially list conditions,	Due to (or as a	consequence of):						
$\overline{J}$	ted 1sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
V	and al-trai	xar	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executed oblysician and the burial-transit	alE	l l	a.							
687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transitians.	dical		1							
	leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 2	23c. If yes, outcome p					23d. Da	te of deliv	very
Вох	eath atter for u	cjar	in the past 12 months?	1□Live birth 2 4□Pregnant at t		⊒Ectopic pregnand ⊒Other <i>(specify)</i> _	У		Mo	onth	Day Year
0	the d / the ched	ysi	1 ☐ Yes 25 No 9 ☐ Unknown	9⊠ Unknown							
Ω.	res that the de igned by the a be detached t		Part II. Other significant conditions con	ntributing to death but	t not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?
ds	uires sign d be	d by						1 🗆	Yes 2 □ No	3 ☐ Pro	bably 450nknown
Records,	v requir been s should	Completed						24a. Was	an 24b.	Were au	opsy findings available
3e	has has	d m							ormed?	death?	ompletion of cause of
<u></u>			OF Mr				26. Place of Dea	1 Yes		1 □ Yes	2 No
Vital	Physician: this certificated director,	Be	25. Was case referred to medical examiner?	Hospital:	nt 2 ER/Outpatier	nt 3 DOA Ot	hor:		idence 6 □Oth	oor (Spor	if <sub>t</sub> ()
ō	Phys this ral di	.T	112 Yes 2 No 27. Manner of Death	28a. Date of Injury				-	how injury occur		1197
n	ding Ph h. After th funeral	.io	1 Natural 5 ☐ Pending	(Month, Day			rk? ]Yes 2∐No				
Division	Attending r death. ector: After you the fune	Certification:	3 Suicide 6 Could not be	28e. Place of inju-	ry - At home, farm, str	reet, factory, office				ber or Ru	ral Route Number,
N	or A after Direction by	it.	4 Homicide determined	building, etc.	."(Specify)			City or To	wn, State)		
_	spitai ours a rerai filled	2	29a. Certifier 1 ★ Certifying Phy	rsician: To the best of	f my knowledge, deat	h occurred at the	ime, date and place	e, and due to the	cause(s) and m	anner as	stated.
	24 hr	ledical	(Check only 2 Medical Exami	iner: On the basis of and manner stat	examination and/or in	vestigation, in my	opinion, death occ	urred at the time	, date and place,	and due	to the cause(s)
	To the Hospitai or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	d (Month	n, Day, Year)
	F S F 0		17	0/1		100	06000	7	August	- Q	2007
	1		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type			•	Mugust	. 0,	2001
	. (		Joseph John Cic				Place H	Baltimo	ore. Mc	1. 2	1202-2102
	St	ate	31. Date filed (Month, Day, Year)	2. Registra	r's Signature				,,		
á	Regist		AUG 0 9 2007	7 Bearing	H. Gra	K)					

DHMH 17 Rev 1/2001

ORIGINAL

	-	State of Maryland / Depar	tment of Health and Menta ificate of Death	ai mygieni Reg. N	200 817	25 99	
Physici	an	1. Decedent's Name (First, Middle, Last)  MARGARET ELIZABETH EMM		ute of Death	2007 Year	3. Time of Death 6:50A M	
/Medi Examir	cal ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Baltimore		
Funeral		5. Social Security Northber 0. Ocx 7. Age (117) To the fact of the security	Timonium  If Under 1 Year   If Under 24 Hrs.   8. Da  Months   Days   Hours   Min.   C. (M)	ite of Birth Conth. Day, Yes Lember 19		lace (State or Foreign	
Director		218-46-2244	Wolfills Days Hours Will. Sep	tember 19	,1945 Mary	<u>l'and</u>	
aryland show	۲	10a. State 10b. County 10c. City, Town or Local	ation		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
the M 28a-f notifie	Director	Maryland Baltimore Towson  10e. Street and Number	10f. Zip Code	10g. C	itizen of What Coun		
th with 23a or ust be	ral D	122 Linden Terrace	21286		USA	an Indian	
partition (e), Mary yial to ZIZI3-00000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other was the medical Examiner must be notified at once.	by Funeral	1 D Nover Married 2 X Varied 1 D Yes X X No	as Decedent of Hispanic Origin? (Specify Y Yes, specify Cuban, Mexican, Puerlo Rican, □ Yes XXX No Specify:	es or No- , etc.)	14. Race - Americ Black, White, Specify: Wh		
in 72 hou n "natura fedical E	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give kife, Du	ont's Usual Occupation ind of work done during most of working O NOT use retired)	16b.	Kind of Business/Ind	dustry	
d with /giene.	Comi		les 18. Mother's Name (Firs:	A Middle Maide	Retail		
d be file ental Hy ked oth	To Be	17. Father's Name (First, Middle, Last)  James O'Brien Donnelly	Rose Mari				
Maly nd 2 shoul lith and M 27 is marl r traumati	1	19a Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Rou inden Terrace Towson				
Pages 1 arent of Hee		20a. Method of Disposition  1 XX Yurial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposicemetery, crem.  St John state	Cemetery 8/8/07	Ну	clocation - City or To	<b>la</b> nd	
Daltillion permit. Pages Department of Important: If i any Injury or once.		21 Signature of Funeral Service Licensee 22.	Name and Address of Facility Mitchel 6500 York Road				
Physician /Medical Examiner		23a. Part1. Enter the disea of or complete cause on earlier that cause the distance of the cause on earlier that cause on earlier that cause on earlier that cause on earlier that cause of cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	r the mode of dying, such as cardiac or resp	orratory arrest,		Approximate Interval Between Onset and Death	
ob / bu, ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			2		
ob/out	edical	d					
death certi	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year	
cords, P.O. w requires that the been signed by the should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		o use contribute to t 2 ☐ No 3 ☐ Pro	V	
The lay ate has bage 2	Completed			24a. Was an autopsy performed 1∐ Yes 2	prior to co death?	opsy findings available ompletion of cause of	
Or VITal Physician: Tripis certifical ral director, p	å	25. Was case referred to medical examiner?  1  Yes	26. Place of Death (Ch.		6 NOther (Speci	HOSOICO	
OPhy Phy er this	on: To	27. Manner of Death 1 Polatural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? 28d.	Describe how in		<i>"</i>	
or Atter or Atter after deal Director in by the	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, streeth building, etc. (Specify)	M 1 Yes 2 No eet, factory, office 28f. L	ocation (Street City or Town, St	and Number or Rui ate)	al Route Number,	
To the Hospital within 24 hours a To the Funeral Completely filled	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invanel and manner stated.	occurred at the time, date and place, and destigation, in my opinion, death occurred a	due to the cause t the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)	
b		30. Name and address of person who completed cause of death (Item 23a) (Type, I EDDIE NAKHUDA, M.D. 2300 DULANEY		TUM, MD	21093		
S Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1. P. 2				

**ORIGINAL** 

			State of Maryland / Department of Health and M state of Maryland / Department of Health and M Per State of No. 1 - State of Maryland / Department of Health and M Per State of No. 1 - State of No. 1 - State of No. 1 - State of No. 1 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of No. 2 - State of N	ental Hygie	ne No.																	
ľ	Physicia	an	1. Decedent's Name (First, Middle, Last)  Margaret Everett	2. Date of Death	Day Year	3. Time of Death																
	/Medic Examin	2.0	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Balton Cre	0	4c. County of Death	I A																
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye MARCH 2/	9. Birth	place (State or Foreign																
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	4	./	10d. Inside City Limits 1   Yes 2 No																
	th the Ma or 28a-f s e notified	Director	MARYLAND N/A LOAL TIMORE  10e. Street and Number 10f. Zip Code	109,	Citizen of What Cou																	
	r death wi	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,																	
9800	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dkal Examiner must be notified at	by	1 Never Married 2	166	Specify: 32	ACK																
21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. cd other than "natural", or Items 23a or 28a-f show event, th. Medi-al Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  TGRAOF  16a. Decedent's Usual Occupation (Give kind of work done during most of work) (Ife. DO NOT use retired)  CHILD CARE PROVIDE		EIF-EMA	OUSILY OF ()																
and 2	2 should be filed and Mental Hygli is marked other aumatic event, the	Be		(First, Middle, Mai	iden Surname)	K																
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Type. Print)  MICHELLE TACKSON (NIECE) 2/26 W, SARATOO	al Route Number, C	ity or Town, State, Zi	o Code)																
-	0 0 L		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or T	own, State																
Baltimore	permit. Pag Department Important: I any Injury o		21. Signatury of Funeral Service Licensee  22. Name and Address of Facility  23. Signatury of Funeral Service Licensee	29 WN	TR. FUNE	RAL HOME																
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of block, or heart failure. List only one cause on each line.	or respiratory arrest	,	Approximate Interval Between Onset and Death																
	Physician /Medical Examiner		disease or condition resulting in death)  a. CM - SYM  Due to (or as a consequence of):	Tiove	3																	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events																			
8760,	ate be executed thysician and the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):  d.																			
Box 6	ath certific ttending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of deliv	rery Day Year																
ds, P.O.	uires that the de signed by the a id be detached t	by	þ	þ	by	þ	þ	by	þ	by	by	by	þ	by	by	by	by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death? bably 4 ∐Unknown
or Vital Records,		Completed		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of																
Vita	slcian: certific rector,	o Be (	examiner? Hospital: Other:	h Check onl one	ce 6 □Other (Spec	ify)																
on or	iding Phys h. : After this funeral di			28d. Describe how																		
Division	al or Atter s after dea l Director d in by the	Certification:	G Could not be	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,																
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.																			
•	To the To the Company	M	29b. Signature and title of certifier  29c. License number  P / 8/124	29d	Date signed (Month																	
	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ryw Annus 22 S. Greene St. Baltin	nove M	D 212	01																
	Sta Regist		Symptonics 31. Date filed (Month, Day, Year)  AUG 0 9 2007  Registrar's Signature  AUG 0 9 2007																			